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SHATTERED HOPES, ENDANGERED LIVES: THE HEALTH AND WELL-BEING OF ADOLESCENT MINORITY MALES IN THE UNITED STATES

A REPORT PREPARED FOR THE OFFICE OF MINORITY HEALTH

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PREFACE

In the mid-1980s, the Department of Health and Human Services (DHHS) issued a report on the health status of minority populations. The development and promulgation of that report reflected a broad-based concern about disparities between the health status indicators for White Americans and those for racial and ethnic minority populations. While that report did not address adolescents specifically, it made apparent the fact that such indicators as premature death rates for minority males were linked directly to health problems which could be addressed during childhood and adolescence. The report also presented recommendations for both direct governmental action, including policies and programs and for private sector and individual involvement in and commitment to addressing the disparities in health status. Several of these related specifically to the health of adolescents and youth.

Since the publication of that report in 1985, the health status of many minority populations and of minority adolescent males in particular has deteriorated. Notwithstanding the increasing concern for the more than five million minority male Americans who are between 10-24 years of age, and the data which give rise to and justify this concern, this population of Americans (in particular Black, Hispanic and Native American youth) - are increasingly characterized as endangered - suffering from profoundly higher risks of diminished quality of life or premature death, in contrast with their White counterparts. Particularly at risk are the estimated two million minority males in this age range who are living in poverty.

This report, prepared for the Office of Minority Health by Policy Research Incorporated, brings together data from a wide range of sources to provide DHHS and others with information that could be used to consider early intervention policies and programs directed toward adolescent minority males, as a means of avoiding, or reducing consequences which arise during adolescence and adulthood. The report takes as a point of departure the World Health Organization definition of health, which includes physical, psychological and social well being. It is hoped that this report can serve as a part of an armamentarium of information for those who recognize the urgency of the situation described in this report and who will assume responsibility for development of immediate and unified policies directed toward this population of American youth. The present patchwork quilt of public and private programs has clearly not been effective in defining and implementing relevant policies and programs to meet their health needs.

Most Americans, buoyed by the apparent economic growth of the 1980s and the tendency to insulate themselves from disquieting revelations, are not aware of the harsh reality of economic and social disparity and the long-term consequences of this disparity for American society in general as well as for the disadvantaged themselves. The problems of minority adolescent males will not go away by themselves nor can they be ignored. Only by confronting them directly, recognizing the problems within the perspective of the interactive systems in which they arise, can we avoid a further deterioration in this decade and beyond. The cost of not confronting this issue in terms of human lives and lost opportunities is too great.

Acknowledgements

Two individuals are primarily responsible for the content of this report: Irene Jillson-Boostrom, who prepared the several draft versions of the socioeconomic indicators sections as well as the introduction and conclusions, and Mae Thamer, who prepared the several draft versions of the health status sections. However, these two individuals also read the drafts of one another's sections, and they could not have written the individual parts of the report without the data and information which Christine Baluck assisted in collecting and archiving. Cora Gordon has been involved from the beginning, commenting on the scope and general approach of this project. Ms. Baluck and Ms. Gordon also reviewed and commented on the several drafts and assisted the authors in preparation of the tables and figures. Yvonne Greene and Peter Schott, both of whom work in Congressional offices, provided data and reports which would otherwise have been difficult to access.

Several specialists in adolescent or public health reviewed a draft version of this report and provided important and useful comments; they are: Moses Pounds, Ph.D., Herbert W. Nickens, M.D. and Rueben Warren, DDS, DrPH. Keith Smith, Ph.D., a noted reviewer of sociological articles and books, and Ruth Smith, an experienced statistician, reviewed several drafts and checked calculations in the text and in tables and figures. Eugene Boostrom, MD, DrPH, a specialist in preventive medicine, reviewed virtually all versions of the report. Ann Meadow reviewed and commented on several parts of the first complete draft of the report. Paul Moss reviewed the socioeconomic sections, providing comments and important additional source material.

Clara Schiffer is in large part responsible for this report's having been prepared, for it is she who supported the idea from the outset, participated in defining the scope of the report, and provided invaluable linkages with other researchers. She also critically reviewed drafts of the report.

Warren Hewitt, the DHHS Project Officer for this report, has contributed to its genesis in numerous ways. He supported the idea for its development and for the concept of placing health status in a larger socioeconomic context. He has painstakingly reviewed the many drafts, providing critical and invaluable comments. He helped to guide the document such that it would be most useful to those who shape public policy with respect to minority adolescent health.

EXECUTIVE SUMMARY

Adolescent minority males constitute one of this nation's most rapidly growing populations, and arguably its most neglected and vulnerable. Although specific health problems vary considerably among different minority groups and subgroups, adolescent minority males in this country in general suffer from by far the highest homicide rate in the industrialized world. Alcoholism rates among certain minority groups are six times those for majority adolescent males. Certain minority male adolescent groups show a six-times higher incidence of high levels of lead in the blood and for the prevalence of tuberculosis. In several categories of health status, the disparities between majority and minority adolescent males have widened at an accelerating rate in recent years.

By the year 2000, nearly one-third of all young adults ages 10-21 will be Black, Hispanic, Native American or Asian American. Their potential to share equally in American society and to contribute to that society, as income earners, family members, community leaders and in other ways, depends in large part on public and private sector decision-makers' recognizing the realities of the deteriorating health and social conditions which beset minority adolescents and implementing effective responses to these conditions.

This report addresses the health and well-being of approximately five million young minority American males ages 10-21 by describing their health conditions and socioeconomic factors which interact with personal characteristics to produce those conditions. The nature and magnitude of many of the problems are clear from available data. However, data inadequacies, an increasing problem, challenge those who need to develop more effective policies and programs; therefore, the report includes specific recommendations to begin to remedy these data deficiencies.

Overall Health Conditions. The gap in Black-White mortality rates has been consistently narrowed over a period of many decades. Over the same time period, U.S. mortality rates in general have dropped dramatically. Since the early 1980s, however, the Black-White gap in mortality rates for males 15-24 has increased. With respect to causes of death, homicide rates for Black adolescents are currently some seven times those for white adolescents and are increasing; homicide rates for some Hispanic and Native American groups approach those for Black youth. Motor vehicle death rates are higher for white adolescents than for most minorities. Suicide rates are higher for White than for Black adolescents, but the rates for Native Americans approach or exceed those for whites. Alcoholism-related death rates for Native Americans are some six times those for the adolescent population generally.

Cigarette use is higher for Black, Native American, and Hispanic adolescent males (and among some Asian subgroups) than for White adolescents, but cigarette use also appears to be more basically related to the educational expectations of adolescents.

Black and Hispanic youth ages 15-24 now comprise fully 47% of the cumulative diagnosed cases of acquired immunodeficiency syndrome (AIDS); AIDS is now the fifth leading cause of death for Black males in this age group. Other sexually transmitted diseases (STDs) are found to be significantly higher among Black and Native American adolescent males than for white adolescent males. Contraceptive use also is significantly lower among minority adolescent males.

Tuberculosis rates among minority adolescent males are up to six times those of white adolescent males, and they are increasing. Diabetes and end-stage renal disease are significantly more prevalent among Native Americans. Among mental health disorders, rates for depression may be substantially higher for minority adolescent males, though the quality of the data introduces uncertainty.

Black adolescent males report lower rates of heavy alcohol consumption than do White adolescent males, but liver cirrhosis and esophageal cancer is much higher in adult Black males. Alcoholism-related death rates among Native American adolescent males are six times those for the corresponding group in the general population.

Black adolescent males exhibit a relatively high rates of heroin and crack use. Native American adolescent males show relatively high rates of marijuana use. Hispanics show high rates for cocaine use. Comparisons of illicit drug use rates among different ethnic and racial groups, and their relative impacts upon health status, are complicated by data problems, with household survey data indicated relatively lower illicit drug use than hospital emergency room and death data indicate.

Socioeconomic Correlates of Minority Health Problems. Minority adolescent males, their health problems and their poor quality of life are inextricably intertwined in a complex causal network involving poverty incomes and the social and personal impacts of these low incomes. For at least the past two decades, more than three times the proportion of Black children, compared to white children, have been living in poverty. More than 2 1/2 times the proportion of Hispanic children, compared to white children, have been living in poverty. These disparities continue today.

As both cause and effect of this poverty, the proportion of lack families headed by women is currently twice the proportion for white families; 63% more Hispanic families are headed by women, and 41% more Native American families are headed by women, compared with White families. Minority families are poor primarily because of low earnings, not because the father is absent. In nearly one-half of all families in poverty at least one member of the family is working, and Black families are twice as likely as whites to find themselves in this situation.

High school dropout rates are much higher for minority males than for whites. Some 36% of Black adult males have not completed high school, and nearly one-half of adult Hispanic males have not done so, compared to 23% of white adult males.

The unemployment rates for young Black and Native American males are nearly three times those for young white males; they are twice as high for young Hispanic males than for their White counterparts. Even when minority males have attained high education levels, their incomes are lower than those of white males with comparable education.

One-fourth of all Black adolescent and adult males who are under some type of control of the criminal justice system (currently jailed, imprisoned, or on parole); this is more than the proportion of Black males in college. The proportion of Hispanic males in the detention system is 10%; for whites the figure is 6%. The population of Black male adolescents in the juvenile detention system has increased by one-fourth in the last decade.

Young minority males are much more likely to be raised in substandard, unsafe housing; Black and Hispanic families in particular continue to be subjected to segregated housing patterns. Nearly 100,00 minority adolescent males live in foster homes, at least 250,000 are homeless, more than 50,000 are incarcerated, and approximately 500,000 are migrant workers.

Addressing Minority Adolescent Male Health Problems. Research has consistently demonstrated important relationships between socioeconomic factors and poor health outcomes and unhealthy behaviors. Many of the poor health outcomes found in minority adolescent males, such as alcohol and drug abuse, smoking, and poor diet can be prevented or treated using known technologies.

Poverty and the lack of adequate social support structures cause minority adolescent males to spend a developmentally significant part of their lives with little or no health insurance coverage. Adolescents who are part of migrant, refugee or homeless families are at especially high risk.

Since at least the early 1980s, the public health community and others have attempted to draw attention to the severe plight of minority males. If the public and private sectors of the United States do not take immediate steps to ameliorate the health and social conditions of this segment of American society, their future may well reflect only their disadvantaged present.

PART ONE:

INTRODUCTION

1.1 IMPORTANCE OF THE ISSUE

In 1985, the Department of Health and Human Services, Office of Minority Health, issued its landmark document, "Report of the Secretary's Task Force on Black and Minority Health."[1] Included in that comprehensive report was a discussion of the significant disparities in mortality rates between White and minority Americans and between minority and White males in particular. The Task Force concluded that, based on these disparities, in 1979-81 there were at least 14,500 excess deaths among Black males under age 45.[2] As defined by the Secretary's Task Force, excess deaths describe the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the White population.[3] The three leading causes of excess mortality for Black males under age 45 were: homicide (accounting for 38% of all excess deaths), followed by infant mortality (23%), and cardiovascular disease (13%).[4] This report stimulated considerable interest in the health status of minority males relative to White males.

Coincidentally, 1985 was also designated by the World Health Organization (WHO) as the International Year of Youth. In that year, the Pan American Health Organization issued a report on health status of adolescents in the Americas, including the United States. This report emphasized that "Current times offer a unique opportunity to focus on and try to solve or prevent the problems of adolescents and youth ... Never before have these problems been so clearly and dramatically defined."[5]

Although public focus tends to be on specific issues such as alcohol and other drug abuse, teenage pregnancy, and violence, severe problems exist with regard to other health status and health service indicators, as well as socioeconomic indicators associated with health status and access to health services. A narrow approach to considering the health status of a population group, one which focuses on health issues exclusively, could obscure the underlying causes of problems and disparities among groups. This approach renders the development of successful public health responses more difficult. When the broad set of health and social indicators is considered, the status of minority adolescent males is much worse than that of White males on a majority of indicators. Moreover, the fact that these differences are occurring at a young age has long term impact on both the life expectancy of minority males and on the diminished quality and productivity of their lives.

In the five years since publication of the Task Force report, concern for the health status of minority adolescents has increased. The public health community is now more cognizant of the fact that, while health indicators for Black and Hispanic American adolescent males have improved over the long term --

concomitant with improvements for the general population -- the past 10 years have seen the disparity escalate between White and minority populations relative to key indicators. For example, certain key indicators such as life expectancy, infant mortality and death rates from certain causes have deteriorated or remained stable for minority males, at the same time that they have improved for other populations.

In an effort to shed light on the complex issues related to the health of the more than five million minority male Americans who are 10-24 years of age, the U.S. Department of Health and Human Services, Office of Minority Health, contracted for the preparation of this background report. Of particular concern to the Office of Minority Health are the estimated two million minority adolescent males who live in poverty.

The primary objective of this report is to provide a single source of information on the health and well-being of minority adolescent males in the United States, for use by policy-makers, health and social service providers and other concerned individuals and organizations. The operative assumption used in preparing this report is that "health" is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[6] The World Health Organization (WHO) uses this broad definition of health in its worldwide effort to achieve Health for All by the Year 2000:

> "Health for all means that health is to be brought within reach of everyone in a given country. And by 'health' is meant a personal state of wellbeing, not just the availability of health services -- a state of health that enables a person to lead a socially and economically productive life... 'Health for all' means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it... 'Health for all' demands, ultimately, literacy for all. Until this becomes reality it demands at least the beginning of an understanding of what health means for every individual. 'Health for all' is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health... The adoption of 'health for all' by a government implies a commitment to promote the advancement of all citizens on a broad front of development, and a resolution to encourage the individual citizen to achieve a higher quality of life. The rate of progress will depend on the political will [of each individual country]."[7]

In order to more fully understand the health and behavioral problems that place minority adolescent males at risk, it was deemed important to present the data and information gathered in a social systems context. As do other population groups, adolescent minority males live in a dynamic and complex system

within which they and their families interact, and on which they largely depend for survival. The manner in which socioeconomic and environmental factors (e.g., housing, education, income and employment) interact with personal characteristics within this system to produce varying health outcomes is unclear. However, research has consistently demonstrated important relationships between these external factors and certain health outcomes such as the relationship between educational attainment and such behaviors as smoking and alcohol abuse. In 1981, the Secretary General of the World Health Organization (WHO), Dr. Mahler, stated:

> "Health does not exist in isolation. It is influenced by a complex of environmental, social, and economic factors ultimately related to each other. The health of the poor is largely the result of a combination of unemployment (and underemployment), poverty, a low level of education, poor housing, poor sanitation, malnutrition, and the lack of the will and initiative to make changes for the better. It would be unrealistic to expect any substantial health improvements in these populations unless these constraints are first removed or alleviated."[8]

1.2 DEFINING ADOLESCENCE AND YOUTH

This report focuses on persons from ages 10 through age 24. Conceptually, adolescence encompasses the transition period from childhood to adulthood, together with the important developmental tasks which must be accomplished to make this transition. It is generally considered to begin at biological puberty and to end when the young person assumes the full responsibilities of adulthood. Spivak[9] has described several developmental tasks which adolescents face:

* individuation from family through a narcissistic period of self-development;

* development of a sexual identity that includes a period of identification with sexual extremes, such as the macho image for males and extreme femininity for females;

* development of a moral and personal value system through experimentation; and

* preparation for future employment and responsibility.

Unfortunately, for purposes of demographic analysis, universally applicable ages for the beginning and end of adolescence have not been specified. Researchers in the field have used different chronological ages to mark the boundaries of adolescence. It is important to recognize that adolescence is a relatively new term which tends to oversimplify a complex developmental stage in which sociocultural factors play such a

large part that the onset and conclusion of adolescence can vary considerably. The DHHS National Institute of Child Health and Human Development (NICHD) has no specific age classification for adolescents. The WHO classification includes those youth between 10 and 20 years of age.[10] Debates regarding the age-group definition of adolescence have been strongly influenced by pediatricians, who in the mid-1970s began to form specialty groups in adolescent medicine. Their age-group definitions were based in large part on biophysical characteristics (e.g., male puberty, female menses). More recently, however, socially and environmentally-induced characteristics have been seen as important in determining which ages should be included in an age classification. These characteristics include, for example, onset of sexual activity. In writing about Black American youth, Jones defined adolescence as:

> "a developmental period, typically ages 13-21 between childhood and adulthood, during which certain physical, cognitive, non-cognitive, legal and educational events occur."[11]

For the purposes of describing the health status of adolescence, the age category is necessarily circumscribed by the availability of data. The lack of widely accepted standards for collection and reporting of data on an "adolescent" age classification severely hampers collection and analysis of data. For example, the relevant age classifications for mortality data widely reported by the National Center for Health Statistics (NCHS) are for the age groups 10-14 and 15-24. Moreover, because adolescents are generally healthy, disinclined to use formal health care delivery, and/or lack financial access to health care delivery systems, data sets which depend on facility-based reporting are likely to be inadequate sources of health status data.

Data related to other health status indicators (e.g., injuries, cigarette smoking) are often reported only for those "18 years and under," with finer breakdowns provided for the adult populations only. In some cases, data collection is rendered difficult or impossible for reasons of confidentiality and/or to protect minors specifically (e.g., data regarding use of contraceptive services, HIV seroprevalence and drug abuse prevalence). The age range covered in this report, 10 to 24 years of age, recognizes the NICHD and WHO classifications as well as the way in which available data are reported.

1.3 RACE AND ETHNICITY

Race/ethnicity is one of the more difficult demographic categories to define and use in analysis because there is no general consensus for classifying subpopulations. Moreover, the definitions have changed over time; three decades ago, the United Nations recommended use of the term "ethnic group", rather than

"race". Today, most health services researchers utilize the classification in collection of epidemiologic data, and it is considered useful as a means of providing data that can be used as the basis for more detailed etiologic studies.[12]

For the purpose of discussion in this report, racial minorities are defined as Black Americans, Native Americans and persons whose origins are Asia and the Pacific Islands. In 1987, Black Americans, constituted 12% of the population[13]; in 1980, the most recent year for which data are available, Asian Americans and Native Americans constituted 1.6% and 1% of the population, respectively.[14] The term Native American includes those frequently referred to as American Indians, Eskimos and Aleuts from Alaska and neighboring islands. Native Americans and Asian Americans are comprised of extremely diverse subgroups with varying cultures; Asian Americans in particular vary considerably in the degree to which they are disadvantaged in the U.S. No national health data are disaggregated by sub-population within this category (e.g., Vietnamese), but to the extent that socioeconomic data and regional data are available by sub-population, they have been included in this report.

Hispanic Americans are the largest ethnic minority population in the U.S. (comprising 8% of the population in 1987) and is also the fastest growing minority group in the U.S., having increased 34% between 1980 and 1988.[15] Hispanic Americans include individuals of White, Black and American Indian origins, and others of mixed racial parentage. The only characteristics which they have in common are: (a) they either have immigrated from, have ancestors from, or have surnames associated with countries that were once under Spanish dominion; and (b) most of them are still Spanish speaking (first or second language). The largest subgroup of Hispanics is the Mexican American population; Puerto Ricans and Cubans represent the second and third largest subgroups. Mexican Americans live primarily in the Southwest, Puerto Ricans in the north and Cubans in southern Florida. More recent immigrants from El Salvador and Guatemala live primarily in the Southwest, but also in the North Central area. These Hispanic subgroups are often found to differ substantially among each other with respect to health and socioeconomic characteristics.

While data are increasingly available for race and ethnicity, the breakdowns are often for "White" and "All others", or "White, non-Hispanic" and "Black, non-Hispanic"; rarely are national data more disaggregated than for these categories. Regrettably, while some national data are disaggregated by age and sex for racial or ethnic groups, rarely are they disaggregated further by education or income status. This would shed light on the relative contribution of these variables to differences in health status or health services utilization among different populations.

In this report, we use the terms White American, Black American, Native American, Hispanic American and Asian American, unless we are directly quoting or extrapolating from tables or documents which use other terminology (e.g., American Indians in lieu of Native Americans). Insofar as possible, we have not used negative descriptors (e.g., non-White, non-poor), unless the original data were classified in this manner. We have not used the term African American, increasingly accepted in lieu of Black Americans, because none of the data available are not reported using this terminology.

1.4 DATA SOURCES AND THEIR LIMITATIONS

This report utilizes existing data and includes information regarding correlates of health status, such as education, family life and environment. When relevant data regarding correlates of health status were not disaggregated by age group, published information which is disaggregated by race and ethnicity and/or gender are presented. For example, data are not available regarding housing conditions of adolescents specifically, so data disaggregated by race and ethnicity and income group are presented. The report presents comparisons for Black, Hispanic and Native American adolescents with White adolescents and/or with the adolescent population in general.

National data are generally not available for Asian American adolescents, nor for Hispanics by national origin (e.g., Puerto Rican, Mexican, Central American), so the few local studies available are presented. Even for Hispanic and Native American adolescents, health and social status data are scarce. The limited nature of the data prevents this report from addressing the full dimensions of the problems encountered by minority adolescents. It should be pointed out that differences between racial and ethnic groups may mask the importance of other factors such as family income and education. To the extent that data are available which clarify the relative importance of these different characteristics, they are presented. Insofar as possible, national data are used. However, regional, state or other data are often included as they are sometimes the only sources of information available about a particular health problem or racial/ethnic group (e.g., nutritional problems of migrant adolescents or the mental health problems of Asian Americans).

In general, "disease"-specific mortality rates are among the most reliable of all available health statistics. Despite this fact, indications (Section 3.2 Mortality) are that deaths among minority adolescent males may not be investigated as closely as deaths among their White counterparts, thereby leading to underestimates for certain causes of death among minority adolescents. Secondly, national mortality rates for Hispanics are not available. Health data for Hispanic male adolescents, both mortality data and other health indicators, come largely from

regional rather than national surveys; among other problems, this means that rural Hispanics are very likely to be underrepresented. On the other hand, Native American adolescents living in urban areas are very likely to be underrepresented in the available health data. Finally, for other ethnic/racial groups, for instance, Asian/Pacific Islanders, national mortality data as well as chronic and acute disease data are unavailable.

The availability of information needed to understand racial and ethnic differentials among adolescent males in disease incidence and impact is unfortunately very limited. This lack of data results from inadequate data collection, which in many cases ignores adolescents, as well as from the larger issue of gaps in health research pertaining to minority populations. With respect to the former, national data on chronic and acute diseases are not available for adolescents specifically. The age category that adolescents are disaggregated into, 18 years and younger, is too broad, and thus generalizations regarding the prevalence of chronic or acute disease conditions from this group to adolescents are inappropriate. With respect to the impact of specific chronic diseases on adolescents, information on activity limitations is not available for Hispanics or Native Americans.

The incidence and the impact of chronic diseases among adolescent males may differ significantly by family income and educational attainment, but information of this kind is limited to small, perhaps unrepresentative groups. In general, it is not possible to estimate the extent to which the differences noted among racial/ethnic adolescents are due to income and education effects.

Much of the information presented in the area of preventive health (including alcohol and other drug abuse) among adolescents focuses on personal behaviors and, as a result, self-reports are the basis for much of the information discussed in this area. Self-reports have obvious drawbacks for all groups, including adolescents. People may fail to report accurately for various reasons such as faulty memory or the social stigma attached to behaviors revealed by the informant. As data are reviewed for group differences among adolescents, it should be kept in mind that differences are bound to be imprecise when based on self-reports. For adolescent males ages 17 and under, a parent or other adult serves as a proxy and reports on the adolescent's health status or personal behavior. The potential for inaccurate reporting is obvious, especially for the older adolescent whose personal behavior in such areas as smoking or substance abuse may not be known to a parent.

Another difficulty in the collection of data used in analyzing health care differences among adolescents stems from the use of household sampling. Sampling by household does not reach a completely representative sample of the population. In particular,

homeless and institutionalized adolescents are not included in these surveys. Similarly, data obtained from school surveys are likely to result in unrepresentative samples because of the inability to obtain responses from school dropouts or those not present or avoiding contact.[16] This is especially the case for data regarding illicit behavior, for example, drug use, which is more likely to be underreported in household surveys. Again, caution is advised when considering group differences because of the possibility of uneven responses.

Notwithstanding the relative lack of health and social indicator data for adolescent minority males, it has been possible to gather and present sufficient data and information to describe the comparative health status of this population, as well as the social indicators associated with their health status. Taken together, these data clearly indicate that this population is significantly disadvantaged relative to their White counterparts.

1.5 LAYOUT OF THE REPORT

The remainder of this report consists of four parts, as follows:

* Part Two: The Adolescent Minority Male in His Social System, which includes three sections, in addition to an overview: The Family, Housing and Environmental Influences, and Education, Employment and Income.

* Part Three: Health Status of Adolescent Minority Males, which includes five sections, in addition to an overview: Mortality, Preventive Health (including sexually transmitted diseases and HIV), Acute and Chronic Conditions (including mental health), Substance Abuse and Injuries.

* Part Four: Financing and Utilization of Health Services, which includes two sections, in addition to an overview: Financing of Services for Minority Adolescents and Utilization of Health Care Services by Minority Adolescents.

* Part Five: Conclusions and Recommendations.

The references for all of the sections are included in Appendix 1, by section. They are presented in Index Medicus format, with the exception that page number citations are provided for all direct quotations.

PART TWO:

THE SOCIAL STATUS OF ADOLESCENT MINORITY MALES

2.1 OVERVIEW TO PART TWO

This section of the report takes as a point of departure the social system's concept of health as described by Mahler (see pp. 2-3 of this report). Given this conceptual basis, an understanding of the socioeconomic status of adolescent minority males, relative to their White counterparts, is essential to an understanding of the health status of this largely disadvantaged population.

The synergistic effects of an adolescent's total environment (family, housing, neighborhood) cannot be overemphasized. For example, the extreme differences in intentional injury and homicide rates by race and ethnicity are direct consequences of the myriad factors which besiege a disproportionate percentage of minority adolescent males. As Spivak has noted:

> "Statistics demonstrate that social and cultural factors such as poverty, racism, availability of weapons, media influences, gender expectations, etc. place certain persons at greater risk of violence. Further, individual factors, such as family history of violence or low self-esteem, substance abuse, weapon carrying, etc. also increase the risk of violence. ... Violence is a learned response to stress and conflict."[1]

As this report will demonstrate, in addition to the growth and development tasks of other adolescent males, minority adolescent males carry on their shoulders the additional burdens of these social, cultural and individual factors, which are themselves interrelated.

Part Two of this report is intended as a preliminary overview for the reader, not as a comprehensive collection and analysis of socioeconomic data concerning adolescent minority males. However, in spite of the fact that it was exceedingly difficult to collect relevant data -- for some indicators and for some racial or ethnic groups they are almost non-existent -- it was deemed important to present those indicators which are most clearly associated with health status. Details related to these indicators can be found in documents and studies cited in this section of the report.

The three aspects of the adolescent minority male's social system which are highlighted in this section of the report are:

* the family, including family composition, foster homes, and adolescent and young adult fathers;

* housing and environment, including housing conditions, homelessness, adolescents as migrants, institutionalized youth, and gangs; and

* education, employment and economic status.

To avoid duplication, some of the data (e.g., income of adolescent migrant farmworkers) are included in sections which relate to other aspects of the system (e.g., housing). Several issues could have been included in more than one section of this report because they relate to multiple aspects of the social system. For example, the discussion of gangs could have been presented in the sections on the family or housing; in this report, it is included with the housing section. Insofar as possible, the implications of the data for other sections are presented in the section in which the discussion appears.

2.1.2 Demographic Indicators

Figure 2.1.1 shows the proportion of persons age 10 to 24 in the U.S. population for 1960, 1970, 1980 and 1987 (the most recent year for which data are available). For all three age groups shown in this figure, the proportion of these adolescent groups in the total population increased between 1960 and 1970 and decreased steadily thereafter. In 1987, this age group represented 16% of the population.[2] This decrease is a reflection of the post-war baby boom and the changes in marriage and birth rates following this population expansion, together with the aging of the population. Thus, adolescents have constituted a decreasing proportion of the total U.S. population since in the past decade, even though their absolute numbers have been increasing.

In 1987, the U.S. resident population aged 10-24 totaled 54.7 million, of whom 10.1 million, or 18.5%, were members of a racial or ethnic minority. Fifty-one percent of those in the 10-24 age group (27.8 million) were male, of whom 5.1 million were racial or ethnic minorities.[3] Figure 2.1.2 presents the 1987 distribution of White, Black and other minority male population for the age group 10-19. Together, minority adolescents accounted for 19% of the total male population in this age group. Figure 2.1.3 shows the distribution of the young adult male population for an older age group, 20-24 for the same year. In this age group, minority males account for a somewhat smaller proportion, 17% of the population. As the 10-19 age cohort grows older, the proportion of minorities in the 20-24 age group will increase.

Over the period 1960-1987, the proportion of White males has only marginally decreased, from 44% of all those (male and female) in the 15-24 age group in 1960 to 42% in 1987. The proportion of Black males in the adolescent (15-24) male plus female population rose only slightly, from 5% in 1960 to 7% in 1987. No population trend data are available for Hispanics and Native American because they are not disaggregated sufficiently to allow for comparisons among the adolescent population.

In the trend data presented above, Hispanic Americans have been classified by the Bureau of the Census as White, Black or other races. This masks the substantial increases in the representation of Hispanics in the general population, which grew 34% from 1980 to 1988 for all age groups; this was the highest rate of increase of any race or ethnic group.[4] The most recent year for which age-disaggregated data are available for Hispanic Americans is 1988. In that year, there were 848,000 Hispanic males aged 15-19 and 1,038,000 aged 20-24; Hispanic adolescents ages 10-19 represented 10% of the total U.S. population in that age group.[5] The Bureau of the Census projects that, in the year 2000, for ages 5-17 and 18-24 (no finer breakdowns are available), Black and Hispanic youth will account for 16% and 12% of the total population in this age group, respectively.[6]

Despite the fragmentary nature of the data, clearly evident in the information shown above, the evidence is sufficient to conclude that the adolescent minority male population has been increasing and will continue to increase, both in terms of absolute numbers and as a proportion of the total male adolescent population in the United States.

2.1.3 Socioeconomic Status of Adolescent Minority Males

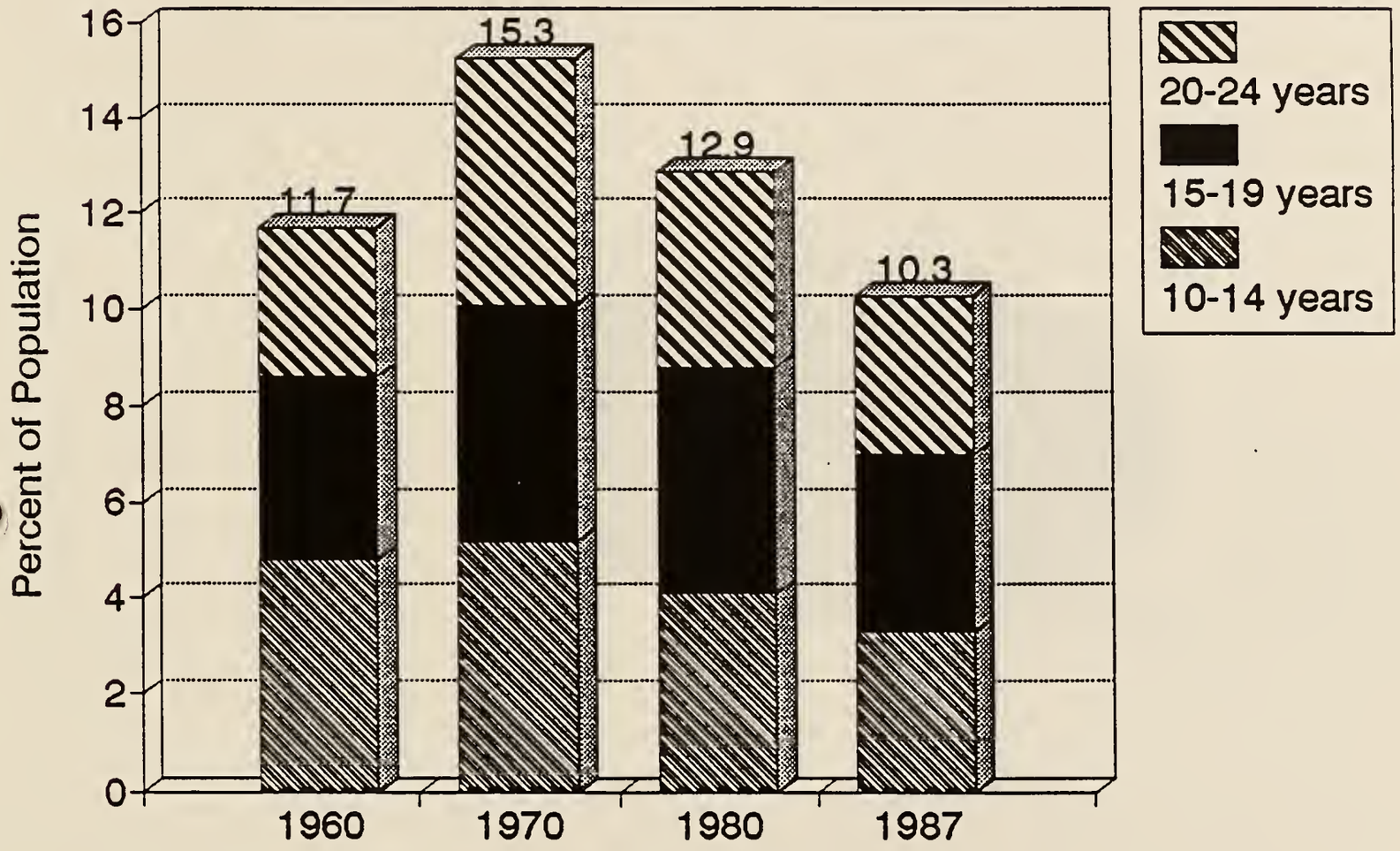
A significant proportion of adolescent minority males is at a severe disadvantage in terms of virtually every socioeconomic indicator. Given the housing conditions in which many are raised, their educational attainment (and that of their families), the income and employment of their families, as well as their own opportunities for employment and actual and potential income level, and the violent and hopeless environment in which so many adolescent minority males live, it is almost surprising that so many survive to adulthood. The dearth of governmental and private sector resources and programs which are available to support the growth and development of adolescent minority males also contributes to limited chances for survival and to reduced quality of life.

Racial and ethnic minority males are more likely than White males to be raised with only one parent (most often the mother) and to be living in larger households which constitute an extended family of care-givers. Minority adolescents are also much more likely to be living in foster homes or juvenile detention centers, the latter with little or no emotional support which could otherwise provide a surrogate for family structures.

Minority adolescent males are disproportionately represented among all adolescents who live in unsafe and unsanitary housing conditions and in environments which are physically or socially conducive to danger and ill-health. Hispanic adolescents in particular are more overrepresented among migrants, whose housing conditions are notoriously substandard.

Racial and ethnic minority youth are at a severe disadvantage with regard to education, employment and economic status, all of which impact synergistically, and which are in turn important co-factors for a number of health status measures. Importantly, their parents are less likely to have graduated from high school or completed college, but are more likely to be unemployed and to have incomes below the poverty line, irrespective of their employment status. In fact, in 1986, 44% of Black children and 38% of Hispanic children under 16 lived in poverty. Black, Hispanic and Native American youth are themselves less likely to complete high school and much less likely to graduate from college. Black, Hispanic and Native American youth have employment rates significantly lower than those of White youth in their same age category and are much more likely to be employed part-time in service industries, at the minimum wage, with little job security and no fringe benefits, such as health insurance.

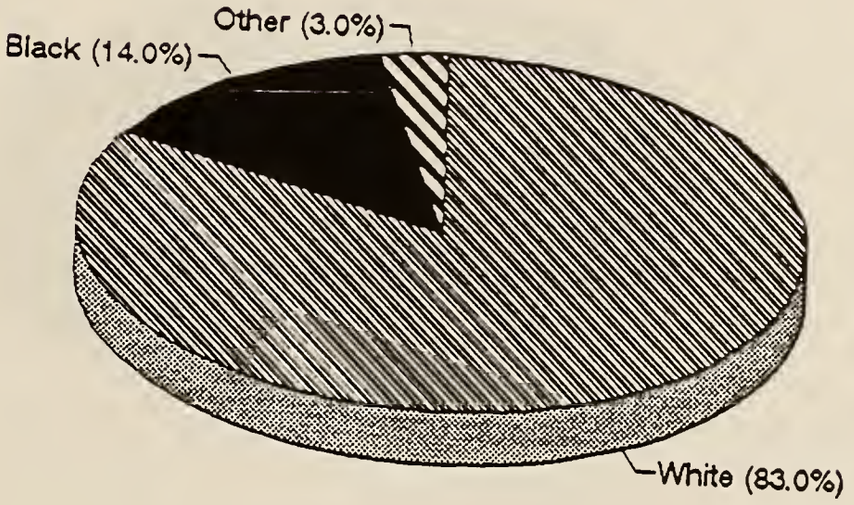
Figure 2.1.1
Proportion of All Adolescents and Young Adults in the U.S. Population for 1960, 1970, 1980 and 1987



Source: Figure prepared by Policy Research Incorporated based on data from: U.S. Department of Commerce. Bureau of the Census. Statistical Abstract of the United States 1989. (109th edition). Washington, DC, 1989, P. 13 and U.S. Bureau of the Census. United States population estimates by age, sex and race: 1980 to 1987. Current Population Reports, Series p-25, No. 1022, Washington, DC, Department of Commerce, Table 2, pp. 23-24

Figure 2.1.2

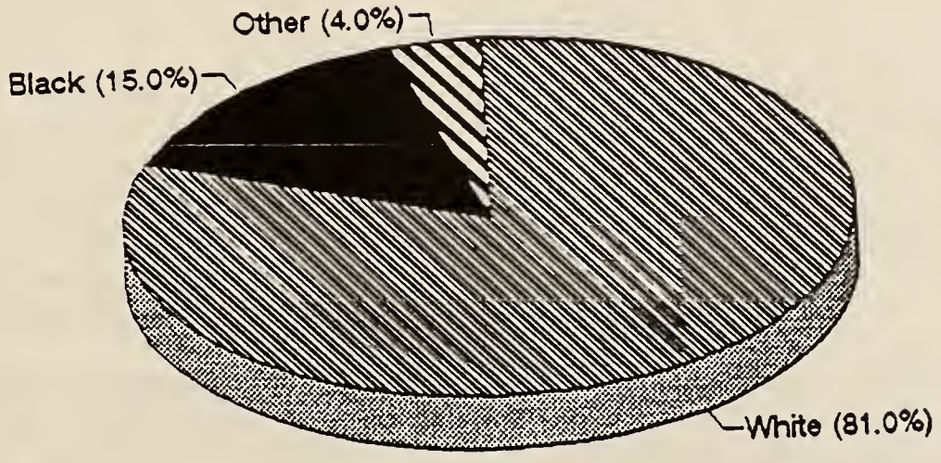
Distribution of White, Black and Other Minority Males, Total U.S. Male Population 10-19, by Race, 1987



Source: Figure prepared by Policy Research Incorporated based on data from: U.S. Bureau of the Census. United States population estimates by age, sex and race: 1980 to 1987. Current Population Reports, Series P-25, No. 1022, Washington, DC, Department of Commerce, Table 2, pp. 23-24

Figure 2.1.3

Distribution of White, Black and Other Minority Males, Total U.S. Male Population 20-24, by Race, 1987



Source: Figure prepared by Policy Research Incorporated based on data from: U.S. Department of Commerce. Bureau of the Census. The Hispanic Population in the United States: March 1988. Washington, DC. Current Population Reports. Population Characteristics Series P-20, No. 438, July 1989, p. 19

2.2 FAMILY

2.2.1 Overview

The home environment in which an adolescent is raised plays an important role in his/her development and physical health. Prolonged poverty and high -- and frequently episodic -- unemployment, among other factors, have substantial impact on family formation, composition, structure and relationships. This becomes particularly significant for those American populations in which unemployment, underemployment and poverty have exerted a cumulative influence for many years, as has been the case with racial and ethnic minority populations in general and Black, Hispanic and Native American males in particular. Adolescents who are members of recent immigrant families have additional burdens (language problems, adjustment to the new culture, loss of their native culture).[1]

Parents and families in minority communities expect that their children will have difficult lives, that they will be required to struggle and confront an often hostile society. This places parents and families in a quandary: is it possible to prepare children for life in such an environment, in particular if social support systems and basic opportunities (e.g., quality education) are severely lacking?

In order to provide the reader with at least some basic data regarding the families in which adolescent minority males are raised, this section of the report presents highlights of recent data regarding family structure and roles, family composition, the extent to which minority youth are overrepresented in foster home placement, and minority adolescent fatherhood.

2.2.2 Family Structure and Roles

As Burgess pointed out in the mid-1960s, "Never before in human history has any society been composed of so many divergent types of families" that vary by geographic region, ethnic and religious groups, socioeconomic status and type of residence.[2] Burgess suggested that, with all these differences, there is an emerging trend toward what he termed a "companionship" form of family, which "emphasizes the point that the essential bonds in the family are now found more and more in the interpersonal relationship of its members, as compared with those of law, custom, public opinion, and duty in the older institutional forms of the family".[3]

Burgess suggested that the distinctive characteristics of what is perceived as "the American family" are derived from 1) earlier forms of the family which developed under varying cultural and socioeconomic conditions, 2) the existing socioeconomic conditions, and 3) the prevailing ideology of the society.[4] Discussions of

the role of family structures vis-a-vis adolescents have been hampered by the fact that research has been largely dominated by a concept of family structure and role that is, essentially, European in origin. According to Nobles,

> "In accepting the White family as the standard family or 'conceptual family', researchers and their research on the Black family have been inextricably bound to an inappropriate comparative model and locked into an inaccurate framework."[5]

This analysis can apply to other racial and ethnic minority groups as well. For many, the "model" which is most recognizable -- the White, middle-class four member family unit portrayed in 1950s television situation comedies -- is, in fact, inapplicable to most American families today.

Gibbs and Huang have noted the importance of age and sex-role hierarchies in defining family relationships among various ethnic groups and different roles of children in assuming household chores and child care. Consistently, racial and ethnic minority children assume these latter roles at an earlier age than do White children.[6]

Franklin and others have described in detail the importance of the family in African American heritage; in fact, according to Franklin, "The family is one of the strongest and most important traditions in the Black community."[7] He further notes that, even under the upheaval of the conditions of slavery, Reconstruction and the Great Depression, the Black family unit included both parents, with multigenerational families (including parents, children and grandparents) common. Until the 1960s, 75% of Black families included both husband and wife.[8] Gibbs and Huang have pointed out that the extended family of relatives and friends is particularly important for low-income Black families, who "exchange resources, services and emotional support". This family structure is important for growth and development of Black youth because "it is not unusual for parents to send adolescents to live with other relatives in order to change their environment or to defuse a conflictual family situation."[9]

While the literature regarding the role of Black families vis-a-vis the Black Adolescent is expanding (see, for example, McAdoo[10] and Nobles[11]), scant literature is available regarding Hispanic and Native American families and their adolescent populations. This may be true in part because, as Gibbs and Huang have pointed out, family structures and roles vary by both country of origin for Hispanic families and tribe for Native American families. According to these authors, Native Americans traditionally "live in relational networks that serve to support and nurture strong bonds of mutual assistance and affections"; for many tribes, collective interdependence still predominates. Thus, for the

Lakota Sioux, for example, problems among Indian youth of an individual family become community problems, in which the tribe becomes involved.[12] Coles described the difference between socialization of Eskimo children and those of Southwestern Native Americans, with the latter being more aloof from and suspicious of White outsiders.[13]

Mexican American families have traditionally strong age-sex hierarchies of power (with males and adults predominating) and a focus on parent/child relationships rather than on marital relationships. Level of acculturation is extremely important for Hispanic families - ethnic differences become less significant in later-generation families.[14] The same problems which pertain to recently immigrated Hispanic youth are true for recent Southeastern refugees as well, with the traditional family structure "in disarray as children more readily acculturate to the host country ... the age-role and sex-role reversals upset the prescribed distribution of power within the family, leading to tension and conflict."[15]

2.2.3 Family Composition

The 1988 Household Survey conducted by the Bureau of the Census showed that White families had an average of 3.1 members per household, of whom 9% were between the ages of 12 and 17. In contrast, Black families had an average of 3.5 members per household, of whom 12% were between the ages of 12 and 17, and Hispanic Americans had an average of 3.8 members per household, of whom 11% were between the ages of 12 and 17. The percentage of households with five or more members differed significantly by race/ethnicity: 13% of White households were in this category, 19% of Black families, and 26% of Hispanic families.[16] In 1980, the most recent year for which data are available, the average size of an Asian and Pacific Islander family was 3.9 (5.2 for Vietnamese) and 3.8 for Native Americans.[17]

In 1987, nearly two million Black families and 729,000 Hispanic families were headed by women with no spouse and with their own children under age 18; this represented 48% of all Black families and 26% of Hispanic families. In contrast, 16% of White families were so characterized.[18] For minority populations, the increase in families headed by females far exceeded that of Whites during the period 1970-1984; for Whites, the increase was 63%, while for Black and Hispanic Americans the increase was 108% and 164%, respectively.[19] In 1980, the most recent year for which data are available, 10.8% of Asian American and 22.7% of Native American families were headed by females with no male present.[20]

In 1987, the most recent year for which data are available, White children and adolescents were far more likely to be living with both parents, or living with one parent, compared with Black or Hispanic adolescents: 79.1% of White children under 18 years

of age lived with both parents; 2.2% lived with neither parent. Only 40.1% of Black children in this age group lived with both parents; 7% lived with neither parent. Sixty-six percent of Hispanic children lived with both parents and 4% lived with neither parent.[21] Notably, in 1987, White and Black adolescent males 15-19 years of age had virtually the same living arrangements; for example 95.3% of White males and 97.4% of Black males in this age group lived with relatives other than a spouse.[22]

Black children were twice as likely to be living in multi-generational families. In 1987, 14% of Black Americans 45-64 years of age, and 10.1% of those 65 years of age and over lived with other relatives (including grandchildren - data are not available for grandchildren separately), versus 6.1% and 6.5% of White Americans.[23] This reflects the importance of the extended family for Black Americans, the concomitant significant role of family members other than parents in care-giving of children, and the converse role of children in care-giving of older relatives. It also is undoubtedly related to the higher income status of elderly White Americans, which afford them the opportunity to live independently; many also live in retirement communities which the relatively poorer minority elderly cannot afford.

It is important that the impact of family structure (in particular, female-headed households) on household poverty not be misinterpreted. While it is true that female-headed, single-parent families are more likely to have incomes below the poverty line, as the National Research Council has pointed out:

> "Had Black family structure remained the same as in 1973, the percentage of poor Black children would have fallen from 41 to 38 instead of rising to 43. ... Rather than family structure, it is low earnings that have led to increased poverty since the 1970s. Many intact Black families are poor because the two adults heading them have very low earning capacities. Likewise, many single-parent families would remain poor if there were two adults present."[24]

Moreover, other factors outside the control of the adolescent or his family play significant roles in family poverty status among racial and ethnic minorities. In the 1987 Urban League report on The State of Black America, Glasgow highlighted

> "the importance of race as a causal factor in the determination of poverty ... [and] the staggering dislocation and disconnection of black males from the labor market, income, and, concomitantly, from the family."[25]

Nevertheless, as Figure 2.2.1 demonstrates, the odds of being in poverty continue to be greater for Black than for White

households which are headed by women,[26] and while being a single-parent, female-headed household is not an isolated factor in family poverty, it is an important contributor. Moreover, as McAdoo suggests, the increasing proportion of single female-headed households has an impact on the social and economic mobility of Black families and youth.[27]

The disproportionate absence of the father in Black and Hispanic households is significant because of the important role of fathers as role models in the socialization of the adolescent male. Unfortunately, even when the father is present, his participation in adolescent socialization may be contingent upon his employment and income status. McAdoo describes the relationship between economic status and parental participation in child-rearing: "when economic sufficiency rises within Black families, an increase in the active participation of the Black fathers in the socialization of his children was observed."[28]

Section 2.4, Education, Employment and Economic Status presents relevant available economic and employment data with regard to minority adolescent males and their families, hopefully shedding light on this important aspect of the minority male and his family.

2.2.4 Foster Homes

In spite of the fact that foster care serves as an important source of family structure for many children and adolescents, very few data are available which could describe the conditions under which many minority youth live and the impact of these alternative arrangements. The general public is largely unaware of the extent to which American children live in foster homes and the fact that this arrangement, originally conceived as a temporary solution to family problems, can in fact be long term. In New York City, children in foster care spend an average of 4.8 years in this system.[29]

While fostering can have positive and adaptive connotations, in practice it can also be disruptive to adolescent development, particularly to their psychological and emotional growth. Minority children are significantly over-represented among children placed in foster homes; nearly half of the estimated 340,000 children placed in foster homes in 1988 were members of a racial or ethnic minority group. Moreover, minority and low income children of all races and ethnic groups wait longer for permanent placement in families than do White children.[30]

According to a recent Congressional report, between 1980 and 1985, there was a 9% decrease in the estimated number of children in official foster care, from 302,000 to 276,000. However, between 1985 and 1988, there was an increase of 23%, to a level higher than of 1980: 340,000.[31]

The substance abuse and human immunodeficiency syndrome (HIV) epidemics are increasingly burdening the foster care system. Studies in New York, California, Florida and the District of Columbia show that caseloads related to substance abuse have increased significantly.[32] The National Black Child Development Institute found that parental drug abuse was a contributing factor in 36% of foster care placements.[33] Thus, foster children come from and sometimes return to unstable families with the potential for child neglect or abuse and exposure to harmful lifestyle habits.

In reporting on a successful alternative to foster home care, Schorr points to

> "the growing recognition that the removal of abused or neglected children from their homes offers few of them good futures... Recent rises in the number of children removed from home reflect in part the fact that financing arrangements continue to provide incentives for out-of-home care and in part the persistent pessimism about whether families, particularly disadvantaged families, can be helped to change for the better."[34]

2.2.5 Adolescent and Young Adult Fathers

Although significant attention has been paid to teenage pregnancy over the past decade or more, relatively little data or information are available regarding attitudes and behaviors of the adolescent male that are relevant to fatherhood (e.g., onset of sexual activity and contraceptive use). This is in spite of the fact that added to this already complex period of development, fatherhood is yet another responsibility for which adolescent males are ill-prepared. Fatherhood affects the adolescent himself, the mother of his child, the child, and the nuclear and extended family of which they are a part.

For almost one-third of teenage births, the age of the father is not listed on birth registration forms. However, the limited data available from the National Center for Health Statistics show that in 1981, 19% of babies born to teenage mothers were fathered by youth between 15 and 19 years of age.[35] A longitudinal study of youths who were between the ages of 14 and 21 in 1979 showed racial and ethnic differences in young fatherhood: among 18 year olds, only .9% of White males had fathered first births, compared to 3.5% of Hispanics and 6.3% of Blacks. At age 19, the differences were essentially the same: 2.5% of White males, 6.3% of Hispanic males, and 11.8% of Black males had fathered children.[36]

In one of the first studies of family planning services for teenagers, conducted in 1976, it was learned that while male attendance was observed in over half of the 40 clinics in the sample, there was little effort directed toward the male.[37] Most

of the literature since then indicates that not much has changed. Therefore, during this important and, for many, confusing stage of physical and emotional development, during which teenagers are involved in critical decision-making, few resources are available to guide them through the personal and social maze.

The marital status difference between Black and White teenagers that is perhaps most reported in the media is the percent of teen mothers who marry during pregnancy. Sixty-two percent of all White teenage girls who had a live birth were married compared to only 10% of all Black teenage girls.[38] However, as Boone points out, it is not the marital status of young Black families that is problematic as much as the fact that inner city fathers are apparently absent.[39] The reasons are often not only involuntary but are also interconnected (if not additive), and relate to socioenvironmental conditions over which the adolescent has little control; homicide, nonfatal injuries, incarceration, and substance abuse effectively remove a large number of young minority men from their families and communities. Moreover, Robinson suggests that, popularly held myths notwithstanding, throughout the pregnancy Black "teenage fathers typically remain involved ... [and that they] do not normally abandon their female partners."[40] In many instances, teenage fathers believe that they must camouflage their involvement because of legal or agency regulations (e.g., Aid to Families With Dependent Children). Whether or not this is the case, teenage fathers are more likely to be intimidated by adult, bureaucratic welfare system.

Glasgow and others have noted the linkage between poverty and the apparent absence of the Black male from his family.[41] Recently, for example, Wilson has noted that there is strong evidence of the

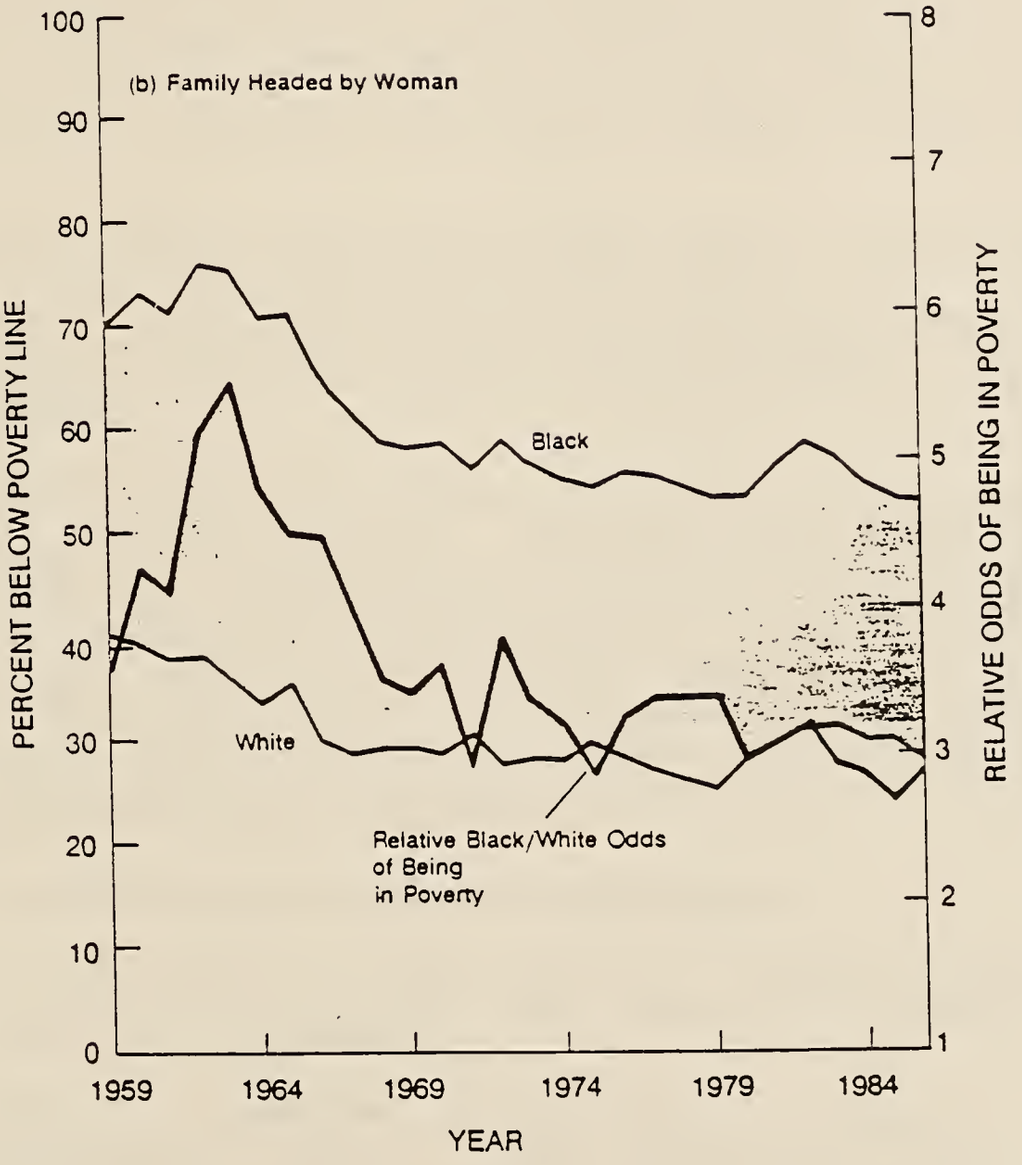
> "relationship between the disintegration of poor Black families and Black male labor-market experiences ... [including] a connection between an encouraging economic situation and the early marriage of young people... The Black delay in marriage and the lower rate of remarriage, each associated with high percentages of out-of-wedlock births and female-headed households, can be directly tied to the unemployment of Black males"[42]

Wilson suggests that "improving the job prospects of men will strengthen low-income Black families ... [and that] underclass absent fathers with more stable employment are in a better position to contribute financial support for their families."[43] Furthermore, Wilson argues that improving their job opportunities would allow them to be independent (a valued characteristic in American society) and to discharge their responsibilities according to social norms.

Data included in Section 2.4 of this report (Education, Employment and Economic Status) support this notion. In 1988, for example, the unemployment rates for Black and Hispanic men ages 18-19 were 31.7% and 19.5%, respectively.[44] Additional information relevant to adolescent male fatherhood (contraceptive use and onset of sexual activity) is included in Section 3.3, Prevention.

Figure 2.2.1

Relative Black/White Odds of Being in Poverty, Female-Headed Households, 1959-1984



Source: National Research Council (Jaynes GD, Williams RM, eds.) A Common Destiny: Blacks and American Society. Committee on the Status of Black Americans. National Research Council. Washington, D.C.: National Academy Press; 1989, p. 281

2.3 HOUSING AND ENVIRONMENT

2.3.1 Overview

An important factor which exerts a major influence on family life and individual health and well-being is the environment in which the family lives, including housing and the physical and social attributes of the immediate community. As this section of the report will demonstrate, a disproportionate number of minority children and adolescents live in substandard housing and crowded conditions or are homeless. Many minority adolescents live in dangerous neighborhoods in which drug marketing and/or use exerts considerable influence or control; are children of migrant workers, moving from one temporary, substandard and often unsafe dwelling to another; or live on reservations or in temporary refuge camps in which the physical conditions and access to basic amenities are deplorable.

The conditions under which human beings grow and develop have inestimable impact on them. Tragically, the conditions under which large numbers of minority males are raised in this country do not bode well for their individual growth and development, nor, by extension, for the future of the society of which they are a part. According to Ellwood:

> "What one sees in America's ghettos is concentration, as poor people are crowded together; isolation, as middle-class families move out; deprivation, as children grow up poor; inferior education, as central city schools decay; and limited opportunity, as low-skill jobs evaporate or move out of the city. Crime and drugs add additional elements. Children living in this environment see few role models, limited opportunity, a poor educational system, intimidating yet respected criminals and a decaying infrastructure. At best, such children are left with despair."[1]

2.3.2 Health Conditions Associated With Housing

According to a report of the National Research Council, injuries which occur in or near the home are related to environmental conditions including:

> "dilapidated or abandoned structures... dangerous uncollected trash or litter ... [and, within the house] unrepaired stairwells and inadequate or absent screens or window guards ...missing smoke detectors ...defective heaters and other household appliances ...[the presence of] toxic substances such as chemicals for pest control or peeling lead paint."[2]

Minority adolescents suffer from a number of adverse health conditions related to the home environment at significantly higher rates than do their White counterparts. For example, non-motor

vehicle injury mortality rates, including accidents taking place in or near the home, are almost twice as high for Black children as for White children ages 10-14; the rates are slightly higher for those 15-19 and 20-24.[3] For Native Americans ages 15-24, the rates were 2 1/2 times those of all other races combined.[4] Black males 10-14 are twice as likely as White males of the same age to die from burns.[5] These injuries have been associated with unsafe housing conditions.

Lead poisoning among children has been a public health concern for some time. In a national survey conducted in 1982, 12.2% of Black children had elevated blood levels of lead, versus 2% of White children. Nearly one-fifth of poor Black children living in the inner city had levels of lead content in their blood higher than the toxic level.[6] Lead poisoning is a critical issue for adolescents because such levels not only cause immediate physical symptoms (e.g., vomiting, loss of appetite), but can have long term effects on the mental and physical growth and development of children. The extent of lead poisoning effects on large numbers of minority children is not known, but given developmentally-related issues, it is clear that this problem may have greater long term significance than previously thought. Further discussion of injuries and lead poisoning is included in Section 3: Health Status.

Unfortunately, it is almost impossible to define explicitly the housing and environmental conditions of minority adolescent males. The data either are not collected or are not published in such a way as to permit such analyses. Recent reports on housing in the United States which presented data disaggregated by race, ethnicity or income status are used in this section of the report to infer, insofar as possible, the conditions under which minority adolescents live.

2.3.2 Housing Conditions

In its recent report on housing in America, the Ford Foundation concluded that, notwithstanding "extraordinary achievements" in housing conditions in the 20th century, three "significant failures" persist; these are:

* the worsening of physical and social decay of inner cities, particularly in older cities;

* the persistence of racially segregated neighborhoods; and

* the rise in real costs of housing, which has greatly exceeded the rise in income and, more importantly, disposable income.[7]

The report concluded that "three trends seem to have contributed to the problem of housing affordability over the past fifteen years" (1975-1989); these were:

* low-income families lost real income at an unprecedented rate;

* housing prices for the poor escalated faster than for any other group; and

* federal support for new subsidized housing was substantially reduced.[8]

According to the Bureau of the Census, in 1985, 44% of Black Americans and 40% of Hispanic Americans were homeowners; in comparison, 67% of White Americans lived in owner-occupied housing.[9] Data included in the most recent Bureau of the Census report on Housing in America show that one-half of Black and Hispanic Americans lived in single family homes, in comparison with 66% for the country overall. Black Americans were three times as likely to live in subsidized housing as the population in general; Hispanics were twice as likely to live in this type of housing (16% of Black Americans, 12% of Hispanic Americans and 5% of all households).[10]

The Joint Center for Housing Studies at Harvard University found recently that 10.3% of all households, and 24% of those below the poverty line, lived in housing defined as inadequate according to U.S. Department of Housing and Urban Development standards which are defined in terms of "presence or absence of plumbing fixtures, heating equipment, and other mechanical subsystems, as well as information on the repair and upkeep of properties."[11] According to the Ford Foundation report, one-sixth of poor families live in dilapidated housing, as do nearly one-third of Black and one-fifth of Hispanic households. Almost 25% of the rural poor live in such housing.[12]

Scarce data are available regarding housing conditions of Native Americans; however, the most recent census data (1980) reveal that for all Indian Health Service (IHS) areas (i.e., reservation areas), the percent of households living in substandard conditions far exceeds that of the United States in general. For example, while only 2.7% of U.S. households lack plumbing and 1.2% have no sewage disposal, 15.6% of households in IHS areas have a complete lack of plumbing and 14.3% have no sewage disposal. Availability of phone service is critical on many reservations because of the large distances of households from health facilities, including emergency medical services, but fully 37% of households in IHS areas had no phone in 1980, compared with 8.3% of U.S. households in general. Some reservation areas were more disadvantaged than others. In the Navajo area, for example, 49.1%

of households had no plumbing, 48.2% had no sewage disposal, and 74.6% had no phone.[13]

As the Ford Foundation pointed out, housing segregation is still a serious problem, so even middle-class minority adolescent males may be victims of segregated housing practices during their developing years. According to the National Research Council (NRC) report on Blacks and American Society, "Blacks of every economic level are highly segregated from whites of similar economic status."[14] The NRC also reported that "in many metropolitan areas one-quarter to one-half of all inquiries by blacks are met by clearly discriminatory responses."[15] Moreover, the relationship between segregation and socioeconomic class -- in turn related to health status -- is circuitous; as Ellwood has pointed out, "a group that is so isolated geographically, economically, and socially will become an underclass."[16] The social and economic isolation which can result from segregation, including isolation from other, more successful role models from the minority male adolescent's race or ethnic background, can contribute further to decreasing opportunities for healthful growth and development, or even for survival.

The Ford Foundation report cites data indicating that two-thirds of all poor families live in housing that costs more than they can afford.[17] Notwithstanding this dramatic situation, as Figure 2.3.1 shows, new budget authority for federally assisted housing decreased precipitously between 1980 and 1988, from $26.7 billion in 1980 to $7.0 billion in 1988. This represents a 78% decline in federal support for housing.

In 1985-86, the median monthly costs for housing were $311 for Blacks, $357 for Hispanics and $355 for all U.S. households. However, both Blacks and Hispanics spent a larger percentage of their income on housing than the population overall: 27% of the income of Blacks and 26% of the income of Hispanics, versus 21% of the income for the population in general.[18] A recent report of the Joint Center for Housing Studies at Harvard University found (based on data from the 1985 American Housing Survey) that 6.6 million poverty-level households in America spend more than half of their income on housing.[19] The Ford Foundation calculated the ratio of housing rent to income by income quartile for selected years since 1974. Figure 2.3.2 presents these data for 1977, 1980 and 1983. Between 1977 and 1983, the rent/income ratio for those in the lowest income quartile increased 24%, while the increase for those in the fourth quartile increased by 16%.

2.3.4 Homelessness

Homelessness is, as Katz has pointed out, "both a condition and a category".[20] Recognizing the growing problem of homelessness in the United States, in 1987 Congress passed the McKinney Homeless Assistance Act. This Act included a definition of

homelessness which was intended to delineate the problem. A homeless person is one who:

> "lacks a fixed nighttime residence or whose nighttime residence is a temporary shelter, welfare hotel, transitional housing for the mentally ill, or any public or private place not designed as sleeping accommodations for human beings."[21]

This definition is viewed by some as flawed because it is not sufficiently inclusive; for example, it excludes those who are temporarily housed with families or friends because they do not have economic access to their own residences. However, even given this definition, which is used extensively as the basis for federal programming, the estimated number of homeless in the U.S. ranges from 200,000-300,000 (in 1984, from the Department of Housing and Urban Development) to 2.2 million (in 1988, from the National Alliance to End Homelessness). For the first time in the history of the Bureau of the Census, the 1990 census, includes an effort to enumerate the number of homeless Americans. It is expected that, because of methodological and practical barriers, the result will undercount (perhaps significantly) the number of homeless.

How many of the homeless are adolescent minority males? While estimates of homeless children have been developed, no studies have specifically attempted to enumerate homeless adolescent minority males. However, the following estimates are indications of the problem among this population:

* According to a recent Congressional report, the number of American children who are homeless on any given night ranges from 50,000 to 500,000.[22]

* The same Congressional report cites a recent study which found that, of 1,000 Black children in foster care in five cities, "inadequate housing was reported as a factor contributing to out-of-home placement of children in 30% of the cases and as one of the remaining barriers of reunification for 34% of children not discharged by the end of the ... study period."[23]

* A recent U.S. General Accounting Office report estimates that 12% of those in shelters are between 13 and 16 years of age, and that as many as 208,000 unaccompanied homeless youths are not counted in estimates of homeless children.[24]

2.3.5 Adolescents as Migrants

Adolescent children of migrant workers and migrant workers who are themselves adolescents are a much-neglected population, and data describing their health and social status are minimal. Nonetheless, as children whose housing, economic, working and

health conditions were described by the late Congressman Mickey Leland as comparable to those found in the Third World,[25] it would be remiss for this report not to address them, however scant the data.

The Department of Agriculture estimates that in 1985, the most recent year for which data are available, between 2.5 and 2.8 million Americans were hired (migrant or seasonal) farmworkers. A migrant farmworker is defined by the Department of Agriculture as "someone who temporarily crosses State or county boundaries and stays overnight to do hired farmwork, or one who has no usual place of residence and does hired farmwork in two or more counties during the year."[26] According to Department of Agriculture data, in 1985, 72% of migrant farmworkers were White, 19% Hispanic and 9% were Black or other. More than one-fifth (22%) of these migrant workers were adolescents between the ages of 14 and 17; 78.5% were male.[27] The average earnings of all hired farmworkers (including migrant workers) was $5,826 in 1985, with workers who were Black (or other) earning 15% less than Hispanic workers ($4,812 versus $5,563) and 20% less than White hired farmworkers (who earned $6,015). The total average earnings of all hired farmworkers was just about half of the poverty level income for that year.[28]

A recent description of migrant housing portrays the substandard conditions in which migrant workers and their families live:

> "The housing available to farmworkers is typically overcrowded, and lacking in even the most basic amenities such as indoor running water or showers, window screens, and in some cases electricity ... due to the overall scarcity of housing, migrant farmworkers are increasingly forced to live in their vehicles or camp out in the fields in which they work."[29]

The National Rural Health Care Association further described the unsanitary conditions of migrant housing:

> "Overcrowded housing units, poor ventilation, and inadequate, faulty, or non-existent plumbing systems further spread disease. Garbage heaps and stagnant water outside housing units breed rats and insects, which harbor and transmit communicable diseases. Some migrants do not have any housing, and are forced to live in the fields where they work, often using contaminated water from irrigation ditches for drinking, cooking, and bathing."[30]

Poor housing conditions of migrant workers has been linked with pesticide poisoning, accidents and sanitation-related diseases[31]; housing conditions have also been linked with an increase in tuberculosis.[32] The health status of adolescent migrant

males is described further, insofar as possible, in Section 3 of this report.

2.3.5 Institutionalized Youth

Juvenile detention centers and other facilities in which youth are placed as a result of convictions for criminal behavior, child abuse or neglect, or emotional problems, can be unhealthy environments in which to grow, particularly in terms of psychological and emotional development. They are considered by many to be the locus of socialization for a lifetime of deviant behavior.

In 1987, the most recent year for which data are available, 91,646 youth were in public and private juvenile detention facilities, a 27% increase over 1979. Of these, 21,000 youth between the ages of 15 and 17 were in long-term, public juvenile institutions.[33] Increasingly, minority populations are disproportionately represented in the juvenile justice system. According to U.S. Department of Justice figures, in 1987 more than half of all juveniles in custody were from a racial or ethnic minority: Blacks accounted for 39%, Hispanics for 15% and Native Americans for 3%.[34]

In fact, since the mid-1960s, studies have consistently shown that Black juveniles are more likely to be arrested and placed in a detention center than are White juveniles for the same conduct.[35] A recent study of sentencing patterns showed that 23% of Black men in the 20-29 age group were "either in prison, jail, on probation, or parole on any given day", in comparison with 10% of Hispanic males and 6% of White males.[36] This same report noted the disturbing statistic that in 1986 there were 40% more Black men who were within the criminal justice system than the total number of Black men of any age enrolled in college; in that year, 600,000 Black men were under some type of control of the criminal justice system. This contrasts sharply with White males, of whom more than four times as may were enrolled in college than were in the criminal justice system in the same year.[37]

In their report on adolescent health, the American Medical Association (AMA) suggested that incarcerated youth "represent a vastly underserved population with greater than average health care needs. ... [and that] Many have underlying, undiagnosed, or untreated physical and emotional disorders, and most lack a coordinated source of regular health care."[38] For example, the AMA report cited studies which found that symptoms of major depression

among approximately 20% of incarcerated juveniles.[39] Incarcerated adolescents constitute a group which, in the words of the American Medical Association, are

> "disenfranchised youth [who] should receive appropriate health care intervention to help them become more productive citizens."[40]

2.3.6 Gangs as an Environmental Influence

The presence of gangs in an adolescent's immediate community can exert important influence on emotional and psychological development, violent and drug using behavior and school performance and attendance. Gangs have been a part of American life since the late 1800s, and have changed both demographically and in terms of roles and structure with successive waves of immigration and with economic trends. According to Thrasher, one of the pioneers of gang research, during the first half of this century, the ethnicity of American gangs changed, but they were always located in the crowded slums of the inner city.[41] However, by the 1960s, according to Hagedorn, fewer gangs whose members were of European origin existed and Black and Hispanic gangs began to predominate. The paradigm remained the same: "the gang experience was the transitory product of the social tensions of immigrant youth newly arrived in a hostile city."[42]

Data consistently show that as employment and economic opportunities become increasingly scarce for minority youth (see Section 2.4 of this report), they are increasingly drawn to participate in gangs. Hagedorn and Macon point out that one difference from the immigrant gangs of the first half of this century to the predominantly minority gangs of the 1980s is "the structural narrowing of the opportunity to mature out of delinquent and deviant ways of life."[43] Racism also plays an important part in the emergence and role of minority gangs in inner city life. Moore [44], Erlanger [45] and Perkins [46] have all demonstrated the role of racial inequality and injustice in the emergence and activities of minority gangs.

Defining "gang" is nearly as complex as defining "family", and as value-laden. As Katz has pointed out, low income and minority youth who engage in collective behavior are seen as members of gangs, while middle class youth who do the same are seen as being part of a "crowd."[47] Moreover, some researchers have pointed to the "subtle, institutional racism dynamics in the juvenile justice system ... [as] one factor to be considered in the over-representation of minority youth,"[48] and in the identification of minorities as gang members. For example, Morales points to a manual used by the Los Angeles police department clearly conditions the officer to "seek out Black and Hispanic youth who conform to the manual's criteria as to who is supposed to be a gang member."[49] Recent research has shown that recruitment of new gang members can

involve children as young as seven or eight years of age, and children in public schools report being attacked or threatened by gang members.[50]

The definition seen as most appropriate by Hagedorn, Moore and others is that of Thrasher:

> "The gang is an interstitial group originally formed spontaneously, and then integrated through conflict. It is characterized by the following types of behavior: meeting face to face, milling, movement through space as a unit, conflict, and planning. The result of this collective behavior is the development of tradition, unreflective internal structure, esprit de corps, solidarity, morale, group awareness, and attachment to a local territory."[51]

An important distinction between middle class and inner city, low-income adolescents who are involved in street fighting groups, according to Katz, is that the former tend to direct their aggression against outsiders, while the latter do so against their peers.[52] This has important implications for the homicide and intentional injury rates among minority adolescent males.

The literature on youth gangs consistently points to the difficulty inherent in estimating the numbers of youth involved in gangs and the magnitude and type of social consequences of gangs. One estimate is that 250 gangs consisting of in excess of 30,000 members exist in the city of Los Angeles alone.[53] Candamil suggests that 300 U.S. cities experience problems with gangs.[54] While much media attention has been directed to gangs (and racial and ethnic minority involvement in same), it is important to recognize that only a small percentage of minority youth are involved in gang activities; notwithstanding the compelling socioeconomic factors which might encourage them to do so.

The relationship between gangs and drug trafficking is of increasing concern. While "traditional" crime organizations (predominantly controlled by White males) remain a dominant force in heroin trafficking, the Drug Enforcement Agency (DEA) has estimated that Asian gangs now control 50% of all heroin trafficking in the United States and that Jamaican, Haitian, Mexican and other gangs are involved in trafficking of illegal drugs.[55] Increasingly, participation in the drug marketing network is seen as an income generating opportunity for lower income youth. Moreover, as Curry and Spergel point out:

> "For disadvantaged youths, uncertain in the face of the unstable urban social world, the gang is responsive and provides quasi-stable, efficient, meaningful social, and perhaps economic, structures. In gang membership, there is the opportunity to obtain the psychic rewards of personal

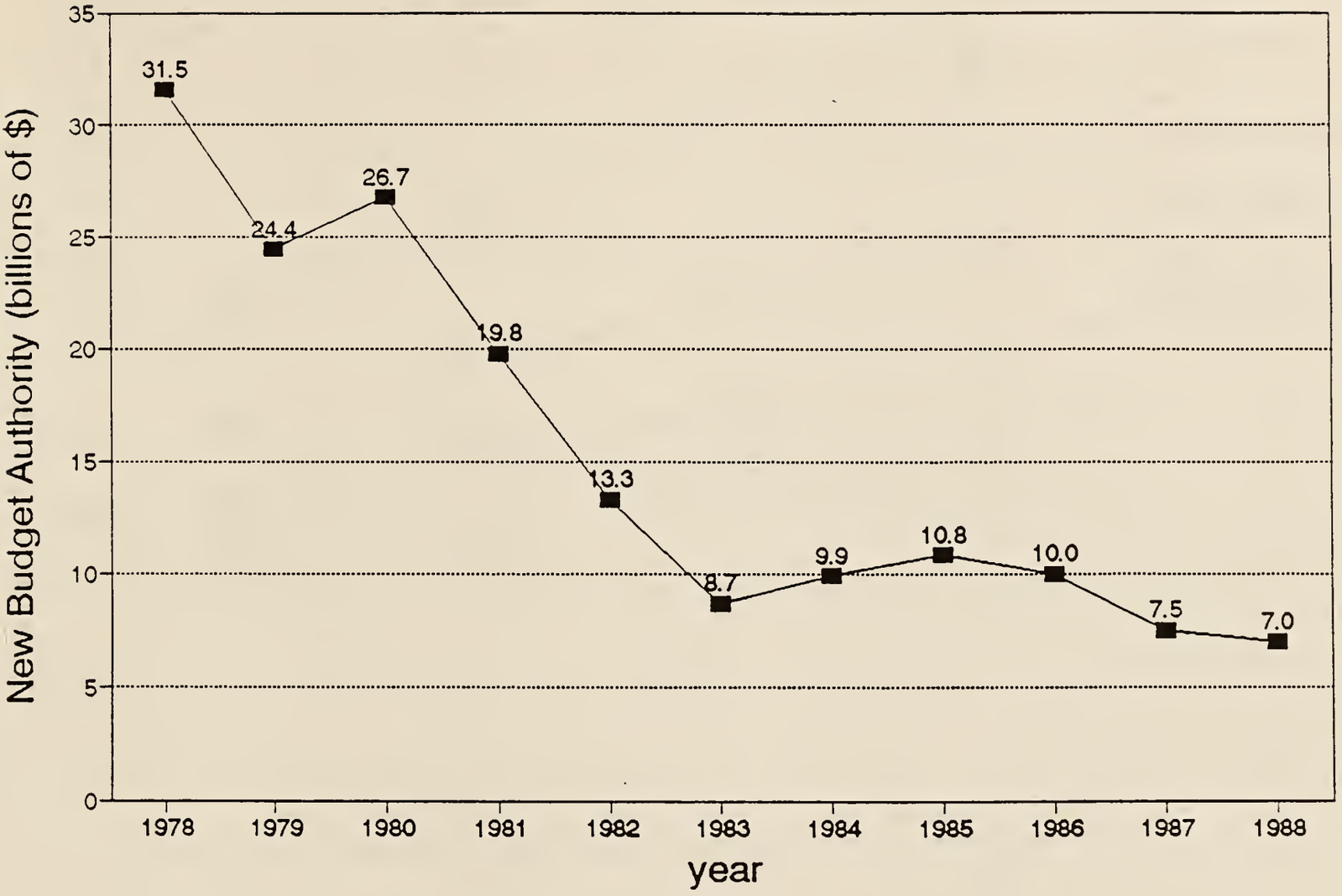
identity and minimal standards of acceptable status and sometimes the material benefits of criminal income."[56]

Notably, involvement in drug trade does not necessarily mean that gang members are using drugs themselves. In fact, according to Chin, drug use is "explicitly rejected by nearly all Chinese gangs in New York City, despite their active involvement in heroin distribution and violence."[57]

A recent federal program funded by the Department of Health and Human Services' Administration for Children, Youth and Families (ACYF) is directed toward community-based prevention of youth gangs. It includes projects which are directed toward racial and ethnic minority involvement in gangs.

Figure 2.3.1

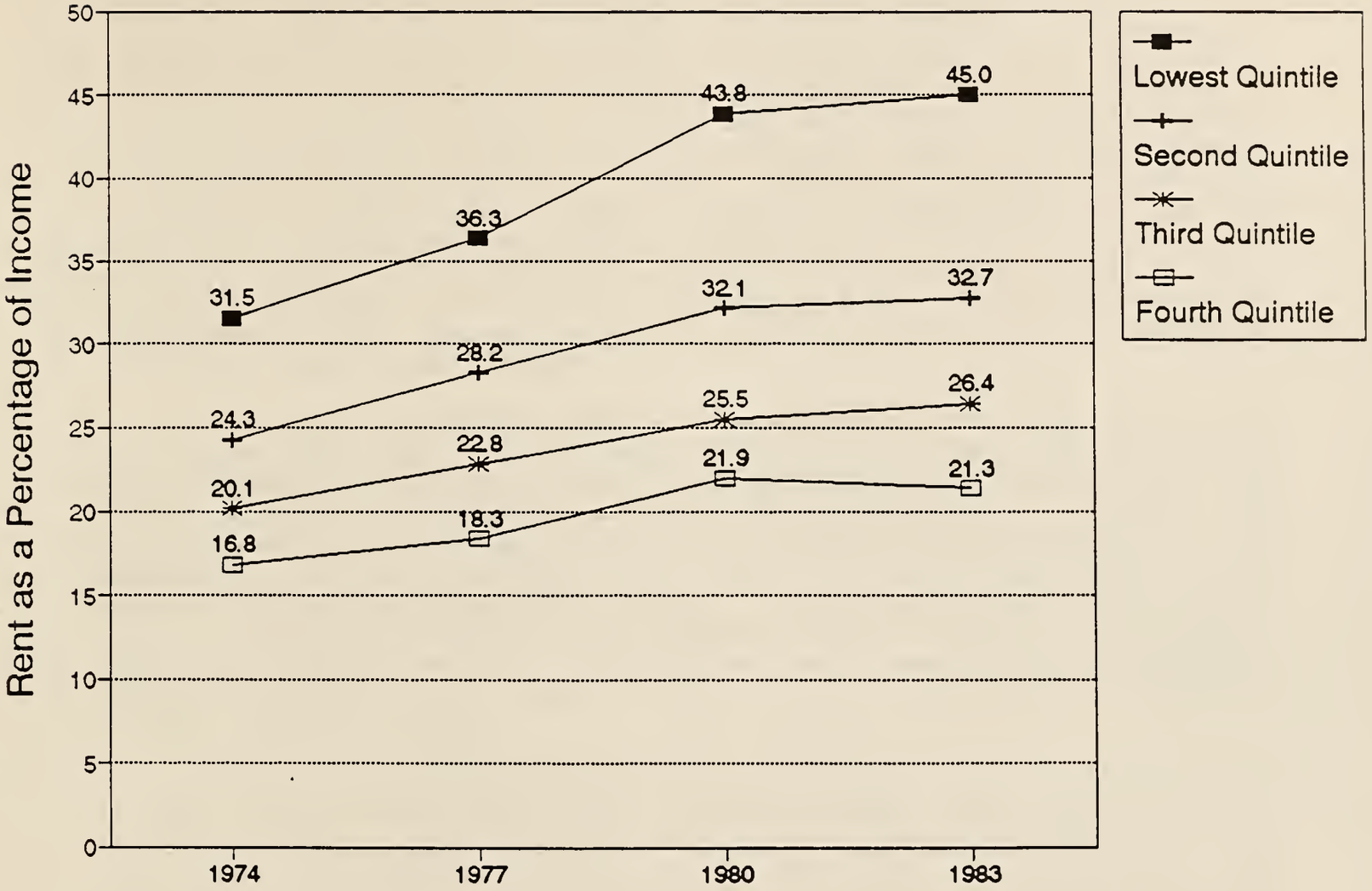
Budget Authority for Assisted Housing, U.S., 1978-1988



Source: Derived from:Clay P. Housing Opportunity: A Dream Deferred. In: National Urban League. The State of Black America 1990. New York, NY: National Urban League; 1990, p. 79

Figure 2.3.2

Rent as Percent of Income by Income Quintile in the United States, 1974, 1977, 1980 and 1983



Source: Prepared by Policy Research Incorporated based on annual housing survey data and interpolations for selected years presented:

Ford Foundation. Affordable Housing: The Years Ahead. New York, NY: Ford Foundation; 1989, p. 48

2.4 EDUCATION, EMPLOYMENT AND ECONOMIC STATUS

2.4.1 Overview

Lower educational attainment and income levels have been consistently correlated with a number of health problems for which minority adolescent males have disproportionately poor rates, including, for example, smoking and hypertension. Similarly, parental educational and employment status can be a determinant of the degree to which an adolescent and his/her family have access to and utilize health care. Throughout Part Three: Health Status, the relationship between the socioeconomic status as represented by education, employment and income level and certain indicators of health are described. Minority males in the United States are much more likely than are White males to be raised in poverty by parents with limited education, to have parents who are minimally or never employed, and to be minimally educated and unemployed themselves. This places them at higher risk for health problems related to these indicators.

Because of the importance of these social indicators for the health and well being of minority adolescent males, relevant data and information regarding education and training, employment and income status, pertaining both to the household in which the minority male is raised and to the young males themselves are summarized in this section. In many instances, the data cannot necessarily be described exclusively for adolescent minority males (e.g., economic status); in these cases, racial and ethnic comparisons for the U.S. population as a whole are presented. Whenever possible, data are provided for the age group of interest in this report (10-24).

Summary social and economic characteristics of the population by race (White and Black) and Hispanic origin for 1987 are shown in Table 2.4.1; comparable data for Asian and Native Americans for 1980 (the most recent year for which the data are available) are presented in Table 2.4.2. Each of the following sections includes a discussion of these and other relevant data and information.

2.4.2 Education and Training

Educational attainment of both parent and child have long been associated with health indicators. Among the health indicators which are correlated with educational levels are: obesity,[1] awareness of relationship between diet and cancer,[2] self-reported healthy lifestyle habits,[3] drug use among high school seniors[4] and smoking.[5]

A Ford Foundation report on unemployment states that:

> "Poorly educated minority youth -- especially dropouts -- living in central cities constitute the core of the problem of youth unemployment. The obstacles such youth face -- low skill levels, limited education, inadequate work experience, discrimination, and poor information about the labor market -- tend to accrete [sic] over time and eventually to become all but irreversible."[6]

High school graduation is frequently used as an indicator of educational attainment; however, there are two approaches to presenting these statistics: 1) for the U.S. population 25 years of age and older, and 2) for the age group of most interest (in this case, adolescents and young adults). Both types of data are included in this report.

Table 2.4.1 shows educational attainment, measured by years of school completed for persons aged 25 years old and over. In 1987, nearly one-quarter (24.4%) of all Americans over 25 had not completed high school. Racial and ethnic differences were striking: 23% of Whites had not graduated from high school, versus 36.6% of Blacks and 49.1% of Hispanics. White Americans were twice as likely to have graduated from college as Blacks in 1987, and more than twice as likely as Hispanics to have done so (20.5%, 10.7% and 8.6%, respectively). Although there has been some improvement since 1980, the racial and ethnic differences have not changed substantially. For example, in 1987, 17.2% of White, 8.4% of Black, and 7.7% of Hispanic Americans had completed four or more years of college.[7]

Comparable data for Native Americans are available only for 1980 (see Table 2.4.2). In that year, more than half of all American Indians had graduated from high school (55.5%), 11% less than the national proportion of high school graduates (66.5%). The disparity with regard to college graduation was even larger: 7.7% of all American Indians 25 years of age and older had graduated from college compared to 16.2% for the U.S. overall. If it can be assumed that the rate of change in the proportion of high school graduates between 1980 and 1987 was roughly the same for Whites, Blacks, and Hispanics, then the proportion of high school graduates among American Indians, Eskimos, and Aleuts in 1987 was lower than for Whites, about the same as for Blacks, and higher than for Hispanics.[8]

The General Accounting Office (GAO) reports that in 1985, Asian Americans were more likely than Americans overall to have graduated from high school (74.8% versus 66.5%), but this varied considerably by origin and ethnic group. For example, only 31.4% of Laotians had graduated from high school. Of the Southeastern Asian refugees aged 17 or over who entered the U.S. between 1978

and 1982, only 22.6% were high school graduates upon entry to the U.S.[9]

Comparative dropout rates for the age cohort 14-34 should be considered as well as educational attainment because the latter data are for the adult population 25 years and older, and therefore do not reflect recent changes in educational experience. High school dropouts are defined by the Bureau of the Census as persons who are not enrolled in school and who are not high school graduates. Figure 2.4.1 shows changes in dropout rates for White, Black and Hispanic males aged 14 to 34 over a 10-year period: 1975, 1980 and 1985. While dropout rates declined overall in this period, the discrepancy between Black, Hispanic, and White rates remains significant: in 1985, Black males were 24% more likely to have dropped out of high school and Hispanic males were nearly 172% more likely to have done so compared to their White counterparts. However, notably, during this 10-year period, the proportion of Black males who were attending or had completed high school increased by 22%, in comparison with White males, for whom the proportion decreased by 2%. Hispanic proportions of those attending or having completed high school increased by 7%.

Among the younger age groups (i.e., those who were adolescents in 1985), there were minimal differences in the dropout rate between White and Black males 14-15 and 16-17 years of age; in fact, the rates are almost the same: 1.6% for White males 14-16 years of age and 1.8% for Black males in that age group. For Hispanic males in the same age group, however, the rate is 3.2%. For males 16-17 years of age, 6.7% of White American youth had dropped out, 7.6% of Black youth had done so, and 10.1% of Hispanic youth had left high school. At 18-19 years of age, the disparity between rates for Hispanic youth and others is striking: 42.2% of Hispanic males in this age group had dropped out of high school, in comparison with 16.3% of young White men and 17.7% of young Black men.[10]

In addition to the relationship between health status and educational attainment, a strong relationship exists between education and income level. For example, in 1988, the median income of married-couple families in which neither husband nor wife had completed high school was $17,386, compared with $40,046 for those who had 13 to 15 years of education. For those families in which both husband and wife had completed college or beyond, the median income was $57,068.[11]

In the mid-1960s, a variety of federal government programs were initiated which were designed to compensate for the impact of the lack of formal educational attainment by minority and low income populations. However, the decade of the 1980s saw many of those programs either eliminated or diminished, at the same time that unemployment and poverty have skyrocketed. For example, during the period 1981-1989, total federal expenditures for

Department of Labor employment, training, and vocational education programs decreased by 38%, from $10.2 billion to $6.3 billion.[12]

Table 2.4.3 shows trends in federal expenditures between 1980 and 1988 for education and training programs in all federal departments (dollar amounts are not corrected for inflation). Funding through 1987 (the most recent year for which final data are available) for those programs most relevant to minority male adolescents are highlighted below:

* The CETA program received $1.38 billion in 1980, but its successor, the Job Training Partnership program, had decreased to $1.33 billion in 1987;

* Department of the Interior funding for Indian Education decreased from $223.1 million in 1980 to $171.2 million in 1981; funding began to increase in 1982, and by 1987 the enacted amount was $218.8 million;

* Veterans Administration non-collegiate and job training programs (which decreased steadily from $440.0 million in 1980 to $119.7 in 1987);

* Department of Health and Human Services Social Security post secondary student benefit program has been a mainstay of opportunities for low-income Americans to pursue higher education; that program's funding decreased from $1.6 billion in 1980 to $25 million in 1985; and

* Department of Education grants for the disadvantaged decreased from 1980 through 1984; in 1985 funding began to increase and by 1987 was at the same level as 1980 ($3.2 billion)[13]

While state governments and the private sector were to have assumed a greater responsibility for these programs, the shortfall is great and unfulfilled. This is evident in the statistics on unemployment, income status, and educational attainment which are included in this report. Phillips has suggested that, during the decade of the 1980s, a significant transfer in wealth occurred in the United States, from the poor to the rich, with federal spending increases benefiting primarily the military-industrial complex, agribusiness and bondholders, and decreases in federal social programs effecting "the poor, the big cities, subsidized housing, education and many other federal social services."[14]

2.4.3 Employment Status

Minority males are much more likely to be raised in families in which one or both parents are not working at any given time than are White males. The unemployment rate for young adult minority males has been significantly higher than that for White Americans

since at least 1964. Figure 2.4.2 presents data for 1964, 1974, 1984 and 1988 for Black and White American males ages 20-24, and for 1984 and 1988 (the only years for which data are available) for Hispanic American males in that age group.

A comparison of employment status of the civilian noninstitutional population 16 years and over for the second quarters of 1988 and 1989 is shown in Table 2.4.4. The unemployment rate showed significant differences by race and ethnicity: the lowest unemployment rate was for Whites, at 4.4 in 1989; the rate for Hispanics was nearly twice that of Whites (8.0%), and was nearly three times as high for Blacks (11.5%). Moreover, the number of discouraged workers increased among Blacks between 1988 and 1989, while it decreased among Whites and Hispanics. (The Department of Labor defines discouraged workers are those who have been searching for work but who have discontinued doing so because they doubt a job can be found.)

For young minority males, the disparity is even greater, and has been worsening since 1964. Table 2.4.5 presents three comparison measures for White and minority males: unemployment rates, civilian labor force participation rates (those either working or looking for work) and employment to population ratios for the years 1964, 1974, 1984 and 1988. On all three measures, and for all three age groups (16-17, 18-19 and 20-24), Black and Hispanic American young men were much more disadvantaged vis-a-vis employment than White men of the same age.

Given the linkages between unemployment and involvement in risk taking behaviors (e.g., drug use, crime), the high rates of unemployment and underemployment among minority adolescents and young men results in their being particularly vulnerable to a host of societal ills. Moreover, the likelihood that unemployed minority youth will ever join the ranks of the steadily employed is minimal. According to the Vice Presidential Task Force on Youth Employment (published in January, 1980):

> "... a small group, containing some whites but mostly blacks and averaging fifteen weeks or more of unemployment annually, accounts for between 70 and 80 percent of the total weeks of youth unemployment. These individuals, who experience long bouts of unemployment, do not show improved employability as they grow older."[15]

The decade since that report has seen an ever-increasing trend toward what the sociologist Keane refers to as "jobless growth" in which there are distinct classes of employees and perpetually unemployed or underemployed persons.[16] In the United States, this has led to a phenomenon which has been termed "permanent underclass". According to Wilson, this is defined as "those who lack training and skills and families who experience long-term spells of poverty and/or welfare dependency."[17] Hagedorn and Macon

describe the means of economic survival used by this disadvantaged population:

> "men and women permanently excluded from participation in mainstream occupations ... who survive...by a combination of economic resources... [including] (a) temporary or part-time jobs in the secondary labor market, (b) temporarily living off relatives or spouse equivalents, (c) the use of transfer payments, like AFDC or General Assistance, (d) subsidized employment, like OJT, CETA, and JTPA, (e) petty hustling or street crime."[18]

The accelerated growth of an American underclass is partly a result of the changing economy in the United States which has had disproportionate impact on minority populations. As a consequence, the changing types of employment affects the degree to which minority male youth receive fringe benefits, including health insurance, which provides access to health care for themselves (and spouse and children, if any).

Consistently, analysis of employment data has shown that those with less than high school education are currently, and in the future, at a severe disadvantage in terms of employability, particularly in large urban areas. For example, in a study of nine cities, there had been a significant decline in employment for those with less than high school education during the period 1970-84. In New York and Philadelphia, cities with large minority populations, the decline had been by nearly one-half million and 172,000 jobs, respectively, for the two cities.[19] The internationalization of the economy, changes in technologies, and macroeconomic policies of the U.S. and other countries have resulted in a significant shift away from manufacturing-based employment. Increases have occurred in both the service industry and professions requiring higher education, and thus exclude the majority of minority males. Unfortunately, service industry jobs are often characterized by part-time, episodic, low-paying jobs which lack opportunity for career advancement and basic fringe benefits such as health insurance.

The disadvantages of low-paying service-industry employment are indicated by the statistics showing the number of <u>employed</u> Americans who live at the poverty level. Data for 1987 show that nearly half (3.3 million) of all Americans who headed households classified as below the poverty level were employed and 1.3 million were employed for 50-52 weeks of the year in which they earned less than the poverty level.[20] Black and Hispanic Americans were more than twice as likely as White Americans to be working, yet living below the poverty level: 5.4% of Whites living below the poverty level in 1987 were working, versus 17.5% of Blacks and 16.2% of Hispanics.[21] Notably, the minimum wage did not change for nine years, remaining at $3.35/hour between January 1981 and April 1990. In 1987, the minimum wage was at its lowest real level since the

1950s.[22] Congressional legislation passed in 1989 increased the minimum wage to $3.80 effective April 1990; it will increase to $4.25 in 1991.[23] Because many Americans who are members of a minority group are employed in service industries, this has significant impact on their earning capacity.

Another indicator of changes in employment opportunities is the fact that between 1974 and 1984 the percentage of Black men ages 20-24 who were employed in manufacturing jobs decreased from nearly half to one-quarter, and their real median income fell by 44%; for White males in this age group, the real median income decreased by 32%.[24] These working poor do not qualify on a means tested basis for much public aid, no matter how poor they are, and participation in the minimal assistance for which they qualify is low among eligible families. Moreover, most do not qualify for Medicaid; the high cost of health care in the United States thus severely limits their access to services for all family members, including children. As the National Research Council has noted:

> "The United States is virtually alone among high-income countries in having no general provisions to protect the well-being and health of children."[25]

The military is increasingly seen as a source of employment and possibly further education by the most motivated and educated young men from the inner cities.[26] According to the Department of Defense, a close association exists between unemployment rates and both military recruitment and retention.[27] While no trend data were readily available for this report, 1988 Department of Defense data show that, while 5.5% of the total U.S. male population between the ages of 16 and 64 were Black, 16.8% of males in the Armed Forces were Black. Hispanic Americans were slightly under represented in the Armed Forces (4% of the total U.S. male population age 16-64 versus 3% of males in the Armed Forces), as were Asian and Pacific Islander males: 2.1% in the population versus 1.3% of males in the Armed Services. Native Americans were slightly overrepresented (.4 of the adult male population versus .5 of males in the Armed Services).[28]

Huff has noted that the "military, a traditionally available alternative career path for the poor, is increasingly inaccessible due to the higher quality of applicants generated by an economy with relatively few attractive entry-level positions for unskilled workers."[29] In view of the importance of the military as a source of both employment and educational opportunities for young minority males, the potential decline in recruitment as result of changing national military policies should prompt the creation of programs to supplant this source.

2.4.4 Income

In 1987, the poverty level was defined as $11,611 for a family of four; 125% of the poverty level was defined as $14,514 for a family of four.[30] In that year, 13.5% of the total population, or more than 32.5 million Americans, lived below the poverty level and nearly one-fifth of Americans (18.1%) lived below 125% of the poverty level (see Table 2.4.6). More than one-third (33.1%) of Blacks and more than one-quarter (28.2%) of Hispanics lived below the poverty level, compared with 11% of Whites. Nearly one-quarter (24%) of families headed by 15-24 year olds were living below the poverty level, while more than half (57%) of Black families and 38% of Hispanic families with similar heads of households were living below the poverty level.[31]

In 1980, the most recent year for which data are available, 23.7% of American Indians, 16.1% of Pacific Islanders and 10.3% of Asian Americans lived below the poverty level. Within the Asian population, wide variations existed between groups; for example, while 35% of Vietnamese (new immigrants) lived below the poverty level, only 4% of Japanese did so.[32]

In 1987, the median household income of White Americans was 43% higher than that of Blacks: $27,427 versus $15,475, and 29% more than that of Hispanics ($19,305).[33] Swinton, writing in the 1990 Urban League report, "The State of Black America," showed that the income gap between White and Black Americans has widened significantly since 1970 [34] (see Table 2.4.7).

In Section 2.4.2 of this report, the significant differences in income by level of educational attainment was described. These differences were notable for all races. However, race and ethnicity are in themselves significant factors in income disparity, notwithstanding educational level. In 1988, the median income of White married-couple families in which both husband and wife had less than 12 years of education was $17,887, vs. $14,590 for comparable Black couples and $16,511 for Hispanic couples. For those with 13 to 15 years of education, the median income was $40,448, $35,692 and $35,964 for Whites, Blacks and Hispanics, respectively. For those who had completed 16 or more years of education, the median income was $57,674, $51,641, and $52,032 for Whites, Blacks and Hispanics, respectively.[35]

Minority males are more likely to be raised in families receiving public assistance (e.g., Aid to Families with Dependent Children, welfare or Medicaid) targeted toward the poor than are White males. A recent report from the Bureau of the Census, based on 1984 data, showed that nearly half (48.5%) of Black Americans and over one-third (34.2%) of Hispanic Americans received this type of assistance at some point in the 32-month period of data collection. Only 13.9% of Whites received such assistance.[36] For

many families on public assistance, however, the amount received is well below the poverty level.

It is important to recognize that the poverty level data reflects a static accounting system; those living at the margin (e.g., 125% - 200% of the poverty level) are likely to be living at less than the poverty level on an episodic basis. In any case, when they are marginally above the poverty level they usually do not qualify for benefits (including Medicaid) to which those below the poverty line may be entitled. Thus, the data presented above are likely to understate the reality of poverty for a large segment of the minority population. Moreover, current private sector and Congressional proposals for increased (including universal) health insurance coverage recognize the limited access to care for the medically indigent, and describe subsidized coverage for those whose incomes fall below the poverty level to 200% of that income level.[37]

2.4.5 Adolescents in Poverty

In 1987, 12.4 million American children under 18 years of age lived below the poverty level, of whom 45% were Black and 39% were Hispanic.[38] In that year, the poverty level was defined as $11,611 for a family of four. For Whites, Blacks and Hispanics, the proportions below the poverty level are highest for children below 16 years.[39] For all children 18 years of age or younger, the percent living below the poverty level increased slightly between 1980 and 1987, from 17.9% to 20.0%. (See Table 2.4.8)

At this same time, there was a 50% increase in the number of American households with an income of over $100,000, from 1.3 million in 1980 to nearly three million households in 1988, of which only 4% were Black and 3% were Hispanic families. Notably, during this same eight-year period, the proportion of families with incomes below the poverty line also increased, albeit only slightly, from 10.3% of all families to 10.4%.[40] According to Philips:

> "The realignment of economic opportunity -- the rich and well-educated grasped it, while the poor and uneducated could not -- devastated the lives of many low-income Americans by removing the jobs and circumstances needed for homes and family cohesion.[41]

Much has been written about the disparity between White and minority children living in poverty; the figures show a deterioration since 1980 (see Table 2.4.8 and Figure 2.4.3). In 1987, 45.1% of Black children under 18 years of age lived in poverty, as did 39.3% of Hispanic children. In comparison, 15.0% of White children lived in these conditions.

Although little has been written about youth living in poverty, the disparity is no less striking for this age group. In 1987, Black and Hispanic youth ages 16-21 were far more likely to be living below the poverty level than were White youth: more than one-third (36%) of Black youth lived in poverty, as did more than one-quarter (28%) of Hispanic youth, in comparison with 12.1% of White youth.[42] No family income data are readily available for Native American and Asian American children.

Based on a regression analysis used to examine the data in Table 2.4.8 for the time period 1970 to 1986, the percentage of children under the age of 18 living in poverty increased at a rate slightly under 1/2% per annum over the course of these 16 years. The increase for White children was similar to those for the total population. While the increase for Black children was slightly less than that of Whites, the proportional difference remained the same or worsened (see Figure 2.4.4). The proportion of Hispanic children living below the poverty level increased at a rate of nearly 1% per year, the fastest increase for any group for which data are available (see Figure 2.4.5).

Table 2.4.1

Social and Economic Characteristics of White, Black and Hispanic Populations in the United States, 1987

[As of March, except labor force status, annual average. Excludes members of Armed Forces except those living off post or with their families on post. Based on Current Population Survey]

CHARACTERISTIC	NUMBER (1,000)						PERCENT DISTRIBUTION					
	Total population [1]	White	Black	Hispanic [2]			Total population [1]	White	Black	Hispanic [2]		
				Total [3]	Mexican	Puerto Rican				Total [3]	Mexican	Puerto Rican
Total persons	238,789	202,453	28,930	18,790	11,762	2,284	100.0	100.0	100.0	100.0	100.0	100.0
Under 5 years old	18,130	14,798	2,728	1,995	1,341	268	7.6	7.3	9.4	10.6	11.4	11.7
5-14 years old	33,972	27,441	5,283	3,691	2,553	482	14.2	13.6	18.3	19.6	21.7	21.1
15-44 years old	113,811	95,892	14,087	9,705	6,006	1,175	47.7	47.4	48.7	51.6	51.1	51.4
45-64 years old	44,901	39,149	4,501	2,493	1,373	280	18.8	19.3	15.6	13.3	11.7	12.3
65 years old and over	27,975	25,173	2,331	906	491	81	11.7	12.4	8.1	4.8	4.2	3.5
YEARS OF SCHOOL COMPLETED												
Persons 25 years old and over	149,144	129,170	15,580	9,449	5,489	1,106	100.0	100.0	100.0	100.0	100.0	100.0
Elementary: 0-8 years	18,941	15,478	2,863	3,330	2,226	319	12.7	12.0	18.4	35.2	40.6	28.8
High school: 1-3 years	17,417	14,233	2,835	1,310	805	193	11.7	11.0	18.2	13.9	14.7	17.4
4 years	57,669	50,690	5,773	2,742	1,496	347	38.7	39.2	37.1	29.0	27.3	31.4
College: 1-3 years	25,479	22,265	2,442	1,257	642	160	17.1	17.2	15.7	13.3	11.7	14.5
4 years or more	29,637	26,505	1,667	810	320	88	19.9	20.5	10.7	8.6	5.8	8.0
LABOR FORCE STATUS												
Civilians 16 years old and over	182,753	156,958	20,352	12,867	7,651	1,540	100.0	100.0	100.0	100.0	100.0	100.0
Civilian labor force	119,865	103,290	12,993	8,541	5,203	827	65.6	65.8	63.8	66.4	68.0	53.7
Employed	112,440	97,789	11,309	7,790	4,690	744	61.5	62.3	55.6	60.5	61.3	48.3
Unemployed	7,425	5,501	1,684	751	514	83	4.1	3.5	8.3	5.8	6.7	5.4
Unemployment rate [4]	6.2	5.3	13.0	8.8	9.9	10.1	(X)	(X)	(X)	(X)	(X)	(X)
Not in labor force	62,888	53,669	7,359	4,327	2,448	713	34.4	34.2	36.2	33.6	32.0	46.3
FAMILY TYPE												
Total families	64,491	55,676	7,096	4,403	2,611	593	100.0	100.0	100.0	100.0	100.0	100.0
With own children [5]	31,898	26,717	4,184	2,859	1,769	432	49.5	48.0	59.0	64.9	67.8	72.8
Married couple	51,537	46,410	3,742	3,118	1,952	314	79.9	83.4	52.7	70.8	74.8	53.0
With own children [5]	24,645	21,787	2,023	2,034	1,359	214	38.2	39.1	28.5	46.2	52.0	36.1
Female householder, no spouse present	10,445	7,227	2,967	1,032	502	257	16.2	13.0	41.8	23.4	19.2	43.3
With own children [5]	6,297	4,141	2,025	729	347	209	9.8	7.4	28.5	16.6	13.3	35.2
Male householder, no spouse present	2,510	2,038	386	253	157	22	3.9	3.7	5.4	5.7	6.0	3.7
With own children [5]	955	789	136	96	63	9	1.5	1.4	1.9	2.2	2.4	1.5
FAMILY INCOME, 1986												
Total families	64,491	55,676	7,096	4,403	2,611	593	100.0	100.0	100.0	100.0	100.0	100.0
Less than $5,000	3,008	1,947	994	381	208	105	4.7	3.5	14.0	8.7	8.0	17.7
$5,000-$9,999	5,022	3,747	1,146	643	365	116	7.8	6.7	16.1	14.6	14.0	19.6
$10,000-$14,999	6,232	5,047	977	668	441	81	9.7	9.1	13.8	15.2	16.9	13.7
$15,000-$24,999	12,613	10,875	1,435	985	629	110	19.6	19.5	20.2	22.4	24.1	18.5
$25,000-$34,999	11,654	10,332	1,043	727	432	80	18.1	18.6	14.7	16.5	16.5	13.5
$35,000-$49,999	12,632	11,461	878	550	323	56	19.6	20.6	12.4	12.5	12.4	9.4
$50,000 or more	13,328	12,267	624	450	212	44	20.7	22.0	8.8	10.2	8.1	7.4
Median income (dol.)	29,458	30,809	17,604	19,995	19,326	14,584	(X)	(X)	(X)	(X)	(X)	(X)
Persons below poverty level	32,370	22,183	8,983	5,117	3,333	898	13.6	11.0	31.1	27.3	28.4	39.4
HOUSING TENURE												
Total occupied units	89,479	77,284	9,922	5,418	(NA)	(NA)	100.0	100.0	100.0	100.0	(NA)	(NA)
Owner-occupied	57,258	51,657	4,505	2,198	(NA)	(NA)	64.0	66.8	45.4	40.6	(NA)	(NA)
Renter-occupied	30,687	24,289	5,245	3,098	(NA)	(NA)	34.3	31.4	52.9	57.2	(NA)	(NA)
No cash rent	1,534	1,338	172	123	(NA)	(NA)	1.7	1.7	1.7	2.3	(NA)	(NA)

NA Not available. X Not applicable. [1] Includes other races and persons not of Hispanic origin, not shown separately. [2] Hispanic persons may be of any race. [3] Includes other Hispanic subgroups not shown separately. [4] Total unemployment as percent of civilian labor force. [5] Children under 18 years old.

Source: U.S. Bureau of the Census, Statistical Abstract of the United States 1989 (109th edition); 1989, Table 44

Table 2.4.2

Social and Economic Characteristics of the Asian, Pacific Islander, American Indian, Eskimo and Aleut Populations in the United States, 1980

[In percent, except as indicated. As of April 1. Based on a sample from the 1980 Census of Population

CHARACTERISTIC	Total population [1]	ASIAN AND PACIFIC ISLANDER												AMERICAN INDIAN, ESKIMO, AND ALEUT	
		Total	Asian							Pacific Islander					
			Total [2]	Chinese	Filipino	Japanese	Asian Indian	Korean	Vietnamese	Total [3]	Hawaiian	Guamanian	Samoan	Total	American Indian
Total (1,000)	226,546	3,726	3,467	812	782	716	387	357	245	260	172	31	40	1,534	1,479
Age:															
Under 5 years old	7.2	8.6	8.4	7.1	9.0	5.2	11.1	10.6	10.0	10.8	10.0	9.1	14.1	10.1	10.1
5-14 years old	15.4	16.8	16.5	14.0	18.1	11.3	16.0	21.7	24.8	20.4	19.2	19.9	25.7	20.8	20.8
15-24 years old	18.7	17.3	16.9	17.9	15.9	17.4	11.3	15.8	23.2	23.1	22.5	26.6	22.5	22.4	22.3
25-34 years old	16.4	21.5	21.8	23.0	20.9	18.9	25.5	21.0	21.6	17.4	16.4	21.7	16.9	18.9	16.9
35-44 years old	11.3	14.2	14.4	12.9	15.5	12.8	18.1	18.0	10.4	11.3	11.7	10.5	10.4	11.1	11.1
45-64 years old	19.7	15.7	15.9	18.1	13.5	27.0	10.1	10.5	8.0	12.8	14.7	9.7	8.4	13.4	13.5
65-74 years old	6.9	3.8	6.1	4.6	5.2	4.2	3.9	1.8	1.4	4.4	3.7	1.6	1.3	3.4	3.4
75 years old and over	4.4	2.1		2.3	2.0	3.1	4.1	.6	.5		1.9	.8	.7	1.8	1.8
Percent foreign born	8.2	58.6	62.1	83.3	64.7	28.4	70.4	81.9	90.5	11.8	1.6	9.5	35.8	2.5	2.5
Years of school completed:															
Persons 25 years old and over (1,000)	132,836	2,137	2,016	495	446	473	239	185	103	119	83	14	15	715	691
Less than 5 years of school	3.6	6.4	(NA)	10.3	7.0	2.3	3.1	4.0	10.3	(NA)	3.2	4.9	5.9	8.4	8.1
4 years of high school or more	66.5	74.8	75.3	71.3	74.2	81.6	80.1	78.1	82.2	67.2	68.4	87.9	61.2	55.5	55.8
4 or more years of college	16.2	32.9	34.3	36.6	37.0	26.4	51.9	33.7	12.9	9.3	9.6	8.2	7.3	7.7	7.7
Labor force status:															
Civilian labor force (1,000)	104,450	1,773	1,687	415	380	395	181	149	86	105	74	13	12	584	567
Percent unemployed [4]	8.5	4.7	4.6	3.6	4.8	3.0	5.8	5.7	8.2	7.3	7.0	8.8	9.7	13.2	13.0
Family type and size:															
Total families (1,000)	59,190	818	765	192	166	168	98	87	42	53	36	7	7	341	331
Married couple	82.8	84.4	85.1	86.8	83.6	84.1	91.0	86.0	72.8	75.4	73.2	79.6	78.0	71.8	71.9
Female householder, no spouse present	13.9	10.8	10.2	8.5	11.8	11.9	5.7	10.6	14.8	19.4	21.3	14.7	18.2	22.7	22.7
Male householder, no spouse present	3.4	4.6	4.7	4.7	4.6	4.0	3.4	3.2	12.4	5.2	5.5	5.8	3.8	5.5	5.4
Average size of family [5]	3.27	3.98	3.96	3.65	4.20	3.59	3.45	4.86	5.16	4.25	4.10	3.94	5.16	3.83	3.82
Family income, 1979:															
Median income (dol.)	19,917	22,713	23,095	22,559	23,667	27,354	24,993	20,459	12,840	17,984	19,196	18,218	14,242	13,724	13,678
Families below poverty level (1,000)	5,670	87	79	20	10	7	7	9	15	8	5	1	2	81	79
Percent below poverty level	9.6	10.7	10.3	10.5	6.2	4.2	7.4	13.1	35.1	18.1	14.3	11.6	27.5	23.7	23.7

NA Not available. [1] Includes other races, not shown separately. [2] Includes all other Asians not shown separately. [3] Includes all other Pacific Islanders not shown separately. [4] Total unemployment as percent of civilian labor force. [5] Refers only to Asian and Pacific Islander persons in primary families with an Asian and Pacific Islander householder.

Source: U.S. Bureau of the Census, Statistical Abstract of the United States 1989 (109th edition); 1989, Table 45

Table 2.4.3

Changes in Federal Funding for Selected Education and Training Programs

In millions of dollars. For fiscal years ending in June. To the extent possible, amounts reported represent outlays, rather than obligations)

LEVEL, AGENCY AND PROGRAM	1980	1982	1983	1984	1985
Total, all programs	34,631.3	34,690.3	34,759.0	36,495.5	38,555.2
Percent of Federal budget outlays	3.9	3.7	3.6	3.6	3.7
mentary/secondary education [1]	16,699.0	15,897.8	15,456.8	17,160.6	16,311.0
Department of Education [1]	5,919.8	7,397.8	6,925.3	7,635.2	8,766.8
Grants for the disadvantaged	3,401.8	2,954.4	3,545.7	3,077.3	3,535.9
Education for the handicapped	821.8	1,141.4	1,289.7	952.9	1,402.8
Rehabilitation services and handicapped research	426.9	1,141.4	948.7	1,414.4	1,414.4
Vocational and adult education	663.4	817.5	717.5	742.5	814.3
Department of Agriculture [2]	4,520.3	3,527.9	3,727.2	4,448.1	4,753.6
Child nutrition programs	3,777.1	3,019.7	3,278.1	3,437.3	3,835.9
Agricultural Marketing Service—Commodities	443.8	253.5	262.3	395.3	730.8
Special milk programs	159.3	22.9	14.9	18.6	16.1
Department of Commerce: Local public works program—school facilities	34.8	5.4	1.3	1.1	-
Department of Defense [1]	370.8	515.3	564.9	712.3	820.3
Junior ROTC	22.0	42.2	50.3	54.1	48.1
Overseas dependent schools	208.8	286.7	414.5	553.6	608.8
Department of Energy	34.9	23.1	58.2	33.2	1.3
Department of Health and Human Services	1,078.3	1,282.6	1,322.0	1,475.7	1,640.1
Head Start	736.0	808.5	912.0	995.7	1,075.1
Social Security student benefits	342.0	374.0	310.0	480.0	565.0
Department of the Interior [1]	334.9	345.2	351.2	411.6	378.5
Mineral Leasing Act and other funds	111.4	172.6	140.9	187.5	147.8
Indian education	223.1	172.2	216.9	223.5	230.2
Department of Labor	1,850.0	1,790.4	1,827.0	1,751.0	1,254.7
Job Corps	570.0	570.0	563.0	595.8	404.5
Job Training Partnership Act [3]	1,280.0	1,220.4	1,264.0	1,155.3	850.2
Department of the Treasury: General Revenue Sharing—Education Share	934.8	911.2	915.3	911.0	914.9
Ve Administration	457.9	310.8	351.1	189.4	169.8
legrate and job training programs	440.0	291.8	244.1	172.2	154.3
Oth lementary/secondary programs and agencies	32.9	38.2	33.3	122.7	100.2
Igher education [1]	10,603.5	10,936.4	10,714.9	10,062.3	10,348.7
Department of Education [1]	5,563.5	5,394.6	5,185.4	5,218.0	5,946.1
Student financial assistance	3,682.9	3,722.5	4,043.6	3,743.3	4,505.8
Guaranteed student loans	1,408.0	3,022.5	2,555.3	3,245.2	2,689.4
Higher education	299.8	379.2	364.4	419.2	476.3
Department of Agriculture	21.5	11.8	15.2	17.2	17.7
Department of Defense	800.0	630.6	698.7	856.5	963.5
Tuition assistance for military personnel	NA	30.8	61.0	68.9	89.4
Service academies	NA	275.3	291.7	392.5	395.0
Senior ROTC	NA	304.5	345.7	395.1	479.2
Higher education—Continued					
Department of Energy	182.4	119.8	29.8	19.7	5.6
University laboratory cooperative program	3.5	3.5	3.5	3.5	3.5
Energy conservation for buildings	77.5	13.6	26.3	16.1	NA
Department of Health and Human Services [4]	2,170.7	2,020.5	1,183.1	483.4	225.8
Health professions training	295.8	268.4	266.9	200.9	207.0
National Health Service Corps scholarships	70.7	59.8	32.0	14.5	8.7
Alcohol, drug abuse, mental health training programs	122.1	100.7	59.4	27.8	11.4
Health teaching facilities	3.1	4.2	40.4	6.1	1.6
Social Security costs/secondary student benefits [5]	1,559.0	1,476.0	770.3	220.0	25.3
Department of the Interior	93.3	96.6	94.6	121.1	92.8
Mineral Leasing Act and other funds	35.4	70.4	70.0	96.1	66.8
Indian programs	27.9	25.3	24.8	25.0	25.0
Department of Transportation	37.1	44.0	43.0	34.0	34.0
Other agencies [1]	2,251.3	1,703.9	1,405.5	1,172.4	1,022.3
Natl Science Foundation—Sci./engineering	64.6	67.5	60.1	29.7	33.0
U.S. Information Agency	49.5	50.0	58.0	17.4	10.2
Veterans Administration	1,784.0	1,525.8	1,258.4	1,070.4	949.2
College student subsidy	1,606.7	1,333.7	1,088.9	839.1	711.0
Post Vietnam veterans	3	14.4	24.9	32.2	37.1
Veterans dependents education	176.3	177.7	154.8	140.2	124.5
Other higher education programs	12.5	11.3	19.0	19.8	19.1
Other programs	1,332.1	1,279.5	1,248.9	1,416.6	1,489.4
Department of Education [4]	458.5	395.9	404.7	422.0	472.6
Libraries	264.8	201.4	224.5	97.1	120.3
Administration	170.1	265.7	248.0	307.4	335.8
Department of Agriculture	274.8	305.5	323.4	339.6	353.2
Department of Health and Human Services	37.8	36.6	44.9	48.9	55.5
Department of Justice	17.4	14.9	19.4	15.4	17.1
Department of State	25.0	21.2	20.8	23.1	25.7
Department of Transportation	12.7	6.0	5.2	2.8	2.9
Other programs and agencies [6]	508.9	489.4	525.6	562.8	540.8
Agency for International Development	80.5	105.4	109.8	101.4	114.8
Library of Congress	151.9	144.9	154.2	164.1	181.2
National Endowment for the Arts	125.9	112.9	121.9	145.4	163.2
National Endowment for the Humanities	95.8	88.4	74.3	74.8	NA
Research programs at universities and related institutions [4]	5,796.7	6,576.8	7,236.3	7,836.3	8,425.1
Department of Defense	644.5	389.9	1,112.2	1,072.5	1,350.0
Department of Energy	1,470.2	1,715.8	1,861.1	2,001.4	2,086.9
Dept. of Health and Human Services	2,087.1	2,194.7	2,448.9	2,750.7	2,910.3
Agency for International Development	77.1	48.6	43.4	109.6	163.9
National Aeronautics and Space Admin	354.6	368.1	366.5	352.9	448.1
National Science Foundation	743.8	737.0	957.8	1,008.0	1,105.7

- Represents zero. NA Not available. Estimated. [1] Includes other programs or agencies not shown separately. [2] Beginning 1982, includes stateside schools on military installations for free education of dependents, previously covered by the Department of Education. [3] Estimate for energy conservation for school buildings ($23.0 million in 1984) not available. [4] Prior to 1983, covers CETA programs.

Source: U.S. Dept. of Education, Center for Statistics, *Digest of Education Statistics*, annual.

Source: U.S. Bureau of the Census, Statistical Abstract of the United States 1989 (109th edition); 1989, Table 202

Table 2.4.4

Employment Status of the Population 16 Years of Age and Over, by Sex, Race, and Hispanic Origin, Second Quarter Averages, 1988 and 1989

(Numbers in thousands)

Employment status	Total[1]		Black		Hispanic origin		White	
	1988	1989	1988	1989	1988	1989	1988	1989
TOTAL								
Civilian noninstitutional population	184,389	186,178	20,652	20,984	13,268	13,731	158,048	159,198
Civilian labor force	121,355	123,780	13,071	13,415	8,908	9,316	104,633	106,401
Participation rate	65.8	66.5	63.3	63.9	67.1	67.8	66.2	66.8
Employed	114,778	117,368	11,477	11,868	8,131	8,571	99,875	101,741
Employment-population ratio	62.2	63.0	55.6	56.6	61.3	62.4	63.2	63.9
Unemployed	6,577	6,412	1,594	1,547	777	745	4,758	4,660
Unemployment rate	5.4	5.2	12.2	11.5	8.7	8.0	4.5	4.4
Median duration in weeks	5.5	5.0	6.7	5.0	4.9	4.2	5.1	4.9
Not in labor force	63,034	62,398	7,560	7,569	4,360	4,415	53,415	52,798
Discouraged workers	842	798	231	274	101	93	554	485
Men								
Civilian noninstitutional population	87,745	88,635	9,272	9,422	6,575	6,794	75,778	76,395
Civilian labor force	67,016	67,948	6,616	6,696	5,361	5,546	58,404	59,124
Participation rate	76.4	76.6	71.4	71.1	81.5	81.6	77.1	77.4
Employed	63,445	64,538	5,815	5,907	4,903	5,159	55,763	56,613
Employment-population ratio	72.3	72.8	62.7	62.7	74.6	75.9	73.6	74.1
Unemployed	3,571	3,411	801	789	458	387	2,641	2,511
Unemployment rate	5.3	5.0	12.1	11.8	8.5	7.0	4.5	4.2
Median duration in weeks	7.0	5.9	7.7	5.7	6.2	4.2	6.8	5.9
Not in labor force	20,729	20,707	2,656	2,726	1,214	1,248	17,373	17,270
Discouraged workers	379	374	89	145	43	24	260	206
Women								
Civilian noninstitutional population	96,644	97,523	11,380	11,562	6,693	6,937	82,270	82,804
Civilian labor force	54,339	55,832	6,455	6,719	3,547	3,770	46,228	47,277
Participation rate	56.2	57.3	56.7	58.1	53.0	54.3	56.2	57.1
Employed	51,333	52,831	5,662	5,960	3,229	3,412	44,111	45,128
Employment-population ratio	53.1	54.2	49.8	51.5	48.2	49.2	53.6	54.5
Unemployed	3,006	3,001	793	758	318	358	2,117	2,149
Unemployment rate	5.5	5.4	12.3	11.3	9.0	9.5	4.6	4.5
Median duration in weeks	4.6	4.5	5.7	4.7	4.1	4.1	4.4	4.5
Not in labor force	42,305	41,691	4,924	4,843	3,146	3,167	36,041	35,527
Discouraged workers	463	424	142	130	58	69	294	279

[1] Detail for the above race and Hispanic-origin groups will not sum to totals because data for the "other races" group are not presented and Hispanics are included in both the white and black population groups.

Source: U.S. Department of Labor. Employment in Perspective: Minority Workers: Second Quarter 1989. Washington, DC: Bureau of Labor Statistics; 1990

Table 2.4.5

Key Employment Measures for Young American Males, by Race and Hispanic Origin, for selected years

Unemployment Rate (1)

Ages	Whites 1964	1974	1984	1988	Blacks 1964**	1974	1984	1988	Hispanics 1980***	1984	1988
16-17	16.1	16.2	19.7	16.1	25.9	39.9	44.0	34.4	26.2	31.5	29.5
18-19	13.3	11.5	15.0	12.4	23.1	28.3	42.2	31.7	19.3	22.2	19.5
20-24	7.4	7.8	9.3	7.4	12.6	16.2	26.6	19.4	12.2	12.5	9.2

Employment-to-Population Ratios (2)

Ages	Whites 1964	1974	1984	1988	Blacks 1964**	1974	1984	1988	Hispanics 1980***	1984	1988
16-17	36.5	44.7	37.8	41.4	27.6	17.0	13.3	19.7	27.3	24.3	25.8
18-19	57.7	65.2	60.1	62.2	51.3	35.9	29.7	36.0	50.6	53.5	51.0
20-24	79.3	79.3	78.0	80.1	78.1	57.6	51.1	56.7	63.8	76.1	68.3

Civilian Labor Force Participation Rates (3)

Ages	Whites 1964	1974	1984	1988	Blacks 1964**	1974	1984	1988	Hispanics 1980***	1984	1988
16-17	43.5	53.3	47.0	49.3	37.3	34.0	26.9	32.7	45.2	35.4	38.6
18-19	66.6	73.6	70.8	71.0	67.2	61.9	56.2	56.0	74.8	68.8	70.1
20-24	85.7	86.6	78.7	86.6	89.4	83.6	79.1	71.3	88.0	87.0	89.4

* Percent of total noninstitutional population with a job
** Includes Blacks and races/ethnic groups other than White
*** Data not disaggregated for Hispanics prior to 1980

Source: U.S. Department of Labor. Handbook of Labor Statistics. Bulletin 2340. Washington, DC: Bureau of Labor Statistics; 1989
(1) Table 28, (2) Table 16, (3) Table 5

Table 2.4.6

U.S. Population Living Below the Poverty Level and at 125% of Poverty Level, by Race and Hispanic Origin, for Years 1959 to 1987

(Persons as of March of the following year. For explanation of poverty level, see text, section 14)

YEAR	NUMBER BELOW POVERTY LEVEL (mil.)				PERCENT BELOW POVERTY LEVEL				BELOW 125 PERCENT OF POVERTY LEVEL		AVERAGE INCOME CUTOFFS FOR NON-FARM FAMILY OF 4 [3]	
	All races [1]	White	Black	Hispanic [2]	All races [1]	White	Black	Hispanic [2]	Number (mil.)	Percent of total population	At poverty level	At 125 percent of poverty level
1959	39.5	28.5	9.9	(NA)	22.4	18.1	55.1	(NA)	54.9	31.1	$2,973	$3,716
1960	39.9	28.3	(NA)	(NA)	22.2	17.6	(NA)	(NA)	54.8	30.4	3,022	3,778
1966	28.5	20.8	8.9	(NA)	14.7	12.2	41.8	(NA)	41.3	21.3	3,317	4,146
1969	24.1	16.7	7.1	(NA)	12.1	9.5	32.2	(NA)	34.7	17.4	3,743	4,879
1970	25.4	17.5	7.5	(NA)	12.8	9.9	33.5	(NA)	35.8	17.6	3,968	4,960
1975	25.9	17.8	7.5	3.0	12.3	9.7	31.3	28.9	37.2	17.6	5,500	8,875
1976	25.0	18.7	7.8	2.8	11.8	9.1	31.1	24.7	35.5	16.7	5,815	7,289
1977	24.7	16.4	7.7	2.7	11.8	8.9	31.3	22.4	35.7	16.7	8,191	7,739
1978	24.5	16.3	7.8	2.6	11.4	8.7	30.8	21.6	34.2	15.8	8,662	8,328
1979 [4]	25.3	16.8	7.8	2.9	11.6	8.9	30.9	21.8	35.6	16.3	7,412	9,265
1979 [5]	28.1	17.2	8.1	2.9	11.7	9.0	31.0	21.8	36.6	16.4	7,412	9,265
1980	29.3	19.7	8.8	3.5	13.0	10.2	32.5	25.7	40.7	18.1	6,414	10,518
1981	31.8	21.8	9.2	3.7	14.0	11.1	34.2	26.5	43.7	19.3	9,287	11,609
1982	34.4	23.5	9.7	4.3	15.0	12.0	35.6	29.9	48.5	20.3	9,862	12,328
1983	35.3	24.0	9.9	4.6	15.2	12.1	35.7	28.0	47.2	20.3	10,178	12,723
1984	33.7	23.0	9.5	4.8	14.4	11.5	33.8	28.4	45.3	19.4	10,609	13,261
1985	33.1	22.9	8.9	5.2	14.0	11.4	31.3	29.0	44.2	18.7	10,989	13,736
1986	32.4	22.2	9.0	5.1	13.6	11.0	31.1	27.3	43.5	18.2	11,203	14,004
1987	32.5	21.4	9.7	5.5	13.5	10.5	33.1	28.2	43.5	18.1	11,611	14,514

NA Not available. [1] Includes other races not shown separately. [2] Hispanic persons may be of any race. [3] Beginning 1981, income cutoffs for nonfarm families are applied to all families, both farm and nonfarm. [4] Population controls based on 1970 census; see text, section 14. [5] Population controls based on 1980 census; see text, sections 1 and 14.

Source: U.S. Bureau of the Census. Statistical Abstract of the United States: 1989 (109th edition). Washington, DC, 1989, Table 734, p. 452

Table 2.4.7

Median Family Income in the United States, for Black and White Families, Selected Years 1970 to 1988

	Median Family Income				Aggregate*
	Black	White	B/W	B/W	Gap
1988	$19,329	$33,915	57.0	$14,586	$111 Billion
1987	19,168	33,725	56.8	14,557	107 Billion
1986	19,001	33,255	57.1	14,254	104 Billion
1985	18,455	32,051	57.6	13,596	99 Billion
1982	16,670	30,161	55.3	13,491	91 Billion
1980	18,196	31,447	57.9	13,251	83 Billion
1978	19,739	33,327	59.2	13,588	80 Billion
1970	19,144	31,209	61.3	12,065	61 Billion

*Equals (Mean White Family Income - Mean Black Family Income) x Number of Black Families

Source: Swinton DH. The Economic Status of Black Americans During the 1980s: A Decade of Limited Progress. In: National Urban League. The State of Black America 1990. New York, NY: National Urban League; 1990, p. 27

Table 2.4.8

U.S. Children Living Below the Poverty Level, 1970-1986, by Race and Hispanic Origin

YEAR AND REGION	NUMBER BELOW POVERTY LEVEL (1,000)				PERCENT BELOW POVERTY LEVEL			
	All races [1]	White	Black	Hispanic [2]	All races [1]	White	Black	Hispanic [2]
1970	10,235	6,138	3,922	(NA)	14.9	10.5	41.5	(NA)
1971	10,344	6,341	3,836	(NA)	15.1	10.9	40.7	(NA)
1972	10,082	5,784	4,025	(NA)	14.9	10.1	42.7	(NA)
1973	9,453	5,462	3,822	1,364	14.2	9.7	40.6	27.8
1974	9,967	6,079	3,713	1,414	15.1	11.0	39.6	28.6
1975	10,882	6,748	3,884	1,619	16.8	12.5	41.4	33.1
1976	10,081	6,034	3,758	1,424	15.8	11.3	40.4	30.1
1977	10,028	5,943	3,850	1,402	16.0	11.4	41.6	28.0
1978	9,722	5,674	3,781	1,354	15.7	11.0	41.2	27.2
1979	9,993	5,909	3,745	1,505	16.0	11 4	40.8	27.7
1980	11,114	6,817	3,906	1,718	17.9	13.4	42.1	33.0
1981	12,068	7,429	4,170	1,874	19.5	14.7	44.9	35.4
1982	13,139	8,282	4,388	2,117	21.3	16.5	47.3	38.9
1983	13,427	8,534	4,273	2,251	21.8	17.0	46.2	37.7
1984	12,929	8,086	4,320	2,317	21.0	16.1	46.2	38.7
1985	12,483	7,838	4,057	2,512	20.1	15.6	43.1	39.6
1986	12,257	7,714	4,039	2,413	19.8	15.3	42.7	37.1
1987	12,435	7,550	4,297	2,631	20.0	15.0	45.1	39.3
Northeast	1,986	1,342	571	600	16.9	13.5	39.4	52.9
Midwest	2,874	1,821	942	184	18.4	13.6	51.5	35.3
South	5,052	2,465	2,511	893	23.4	15.7	45.9	43.7
West	2,522	1,922	273	953	18.9	16.9	35.4	31.9

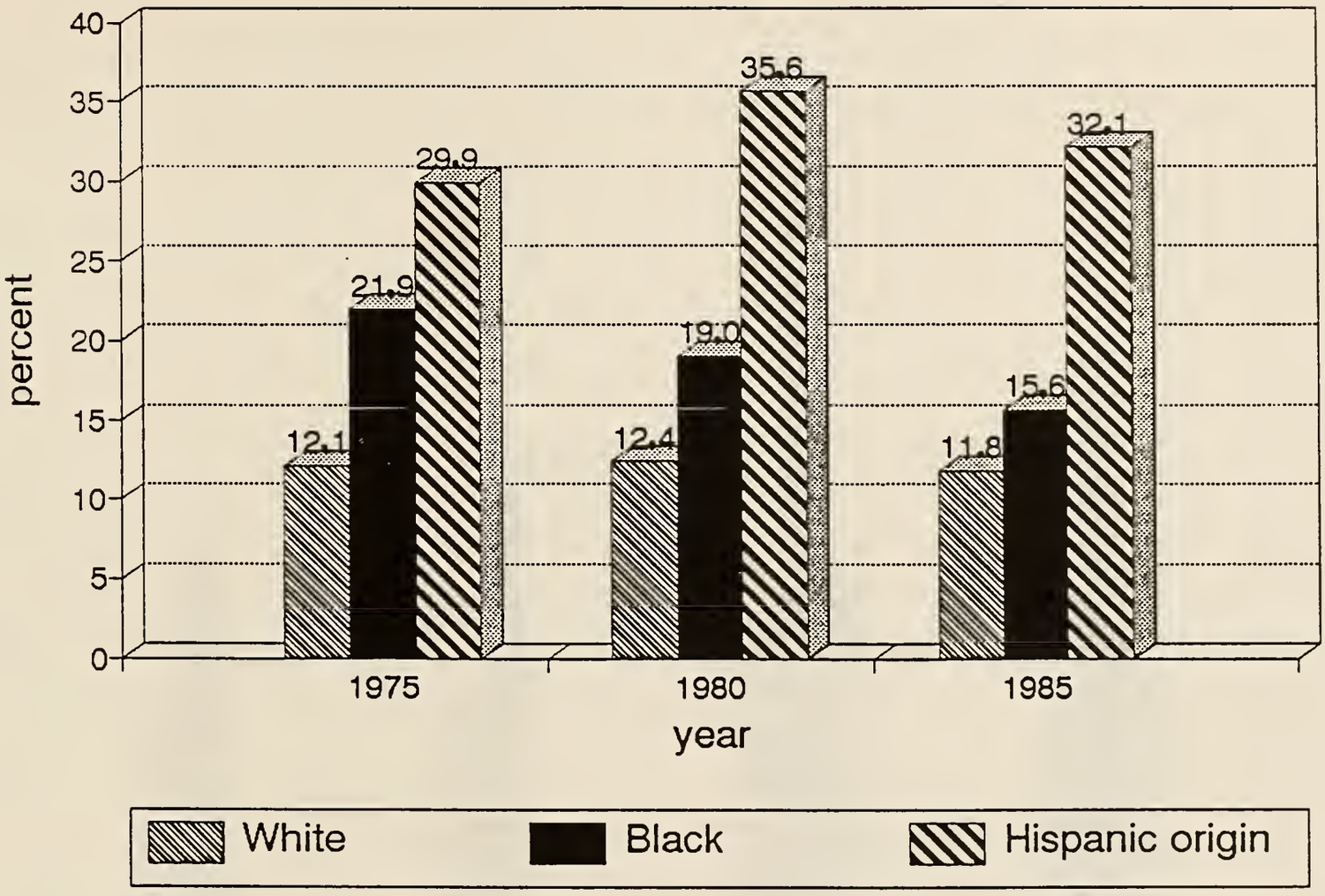
NA Not available. [1] Includes persons of other races, not shown separately. [2] Hispanic persons may be of any race.

Persons as of **March** of the **following year.** Covers only related children in families under 18 years old.

Source: U.S. Bureau of the Census. Statistical Abstract of the United States: 1989 (109th edition). Washington, DC, 1989, Table 738, p. 454

Figure 2.4.1

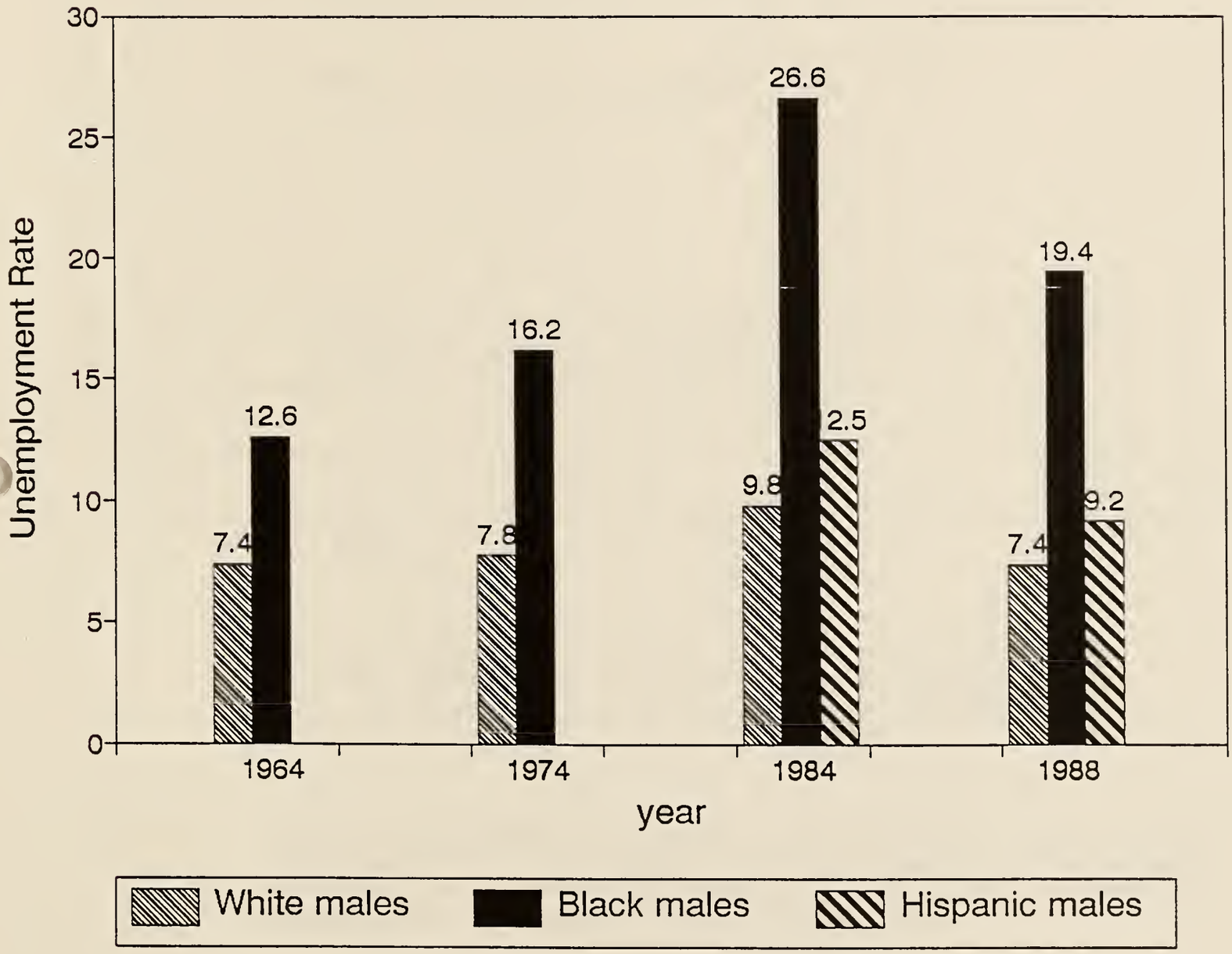
Percentage of High School Dropouts Among U.S. Males 14 to 34, by Race and Ethnicity, 1975, 1980, 1985



Source: Reed, RJ. Education and Achievement of Young Black Males. In: Gibbs JT, ed. Young, Black and Male in America: An Endangered Species. New York, NY: Auburn House Publishing Company; 1988, Table 2-13

Figure 2.4.2

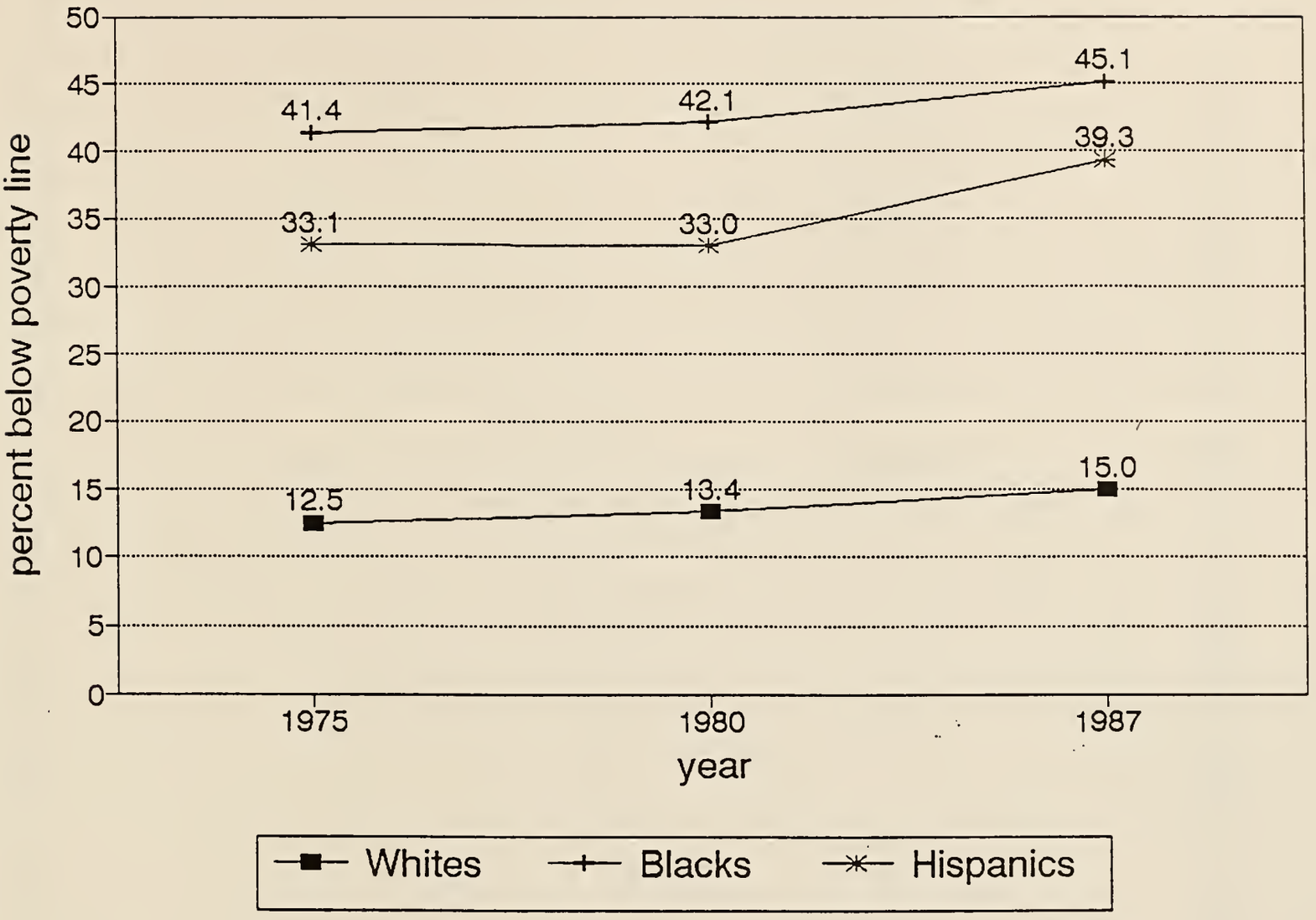
Percent of Unemployed U.S. Males Ages 20-24, by Race and Hispanic Origin, 1964, 1974, 1984 and 1988



Source: Prepared by Policy Research Incorporated based on data included in: U.S. Department of Labor. Handbook of Labor Statistics. Bulletin 2340. Washington, DC: Bureau of Labor Statistics; 1989
(1) Table 28, (2) Table 16, (3) Table 5

Figure 2.4.3

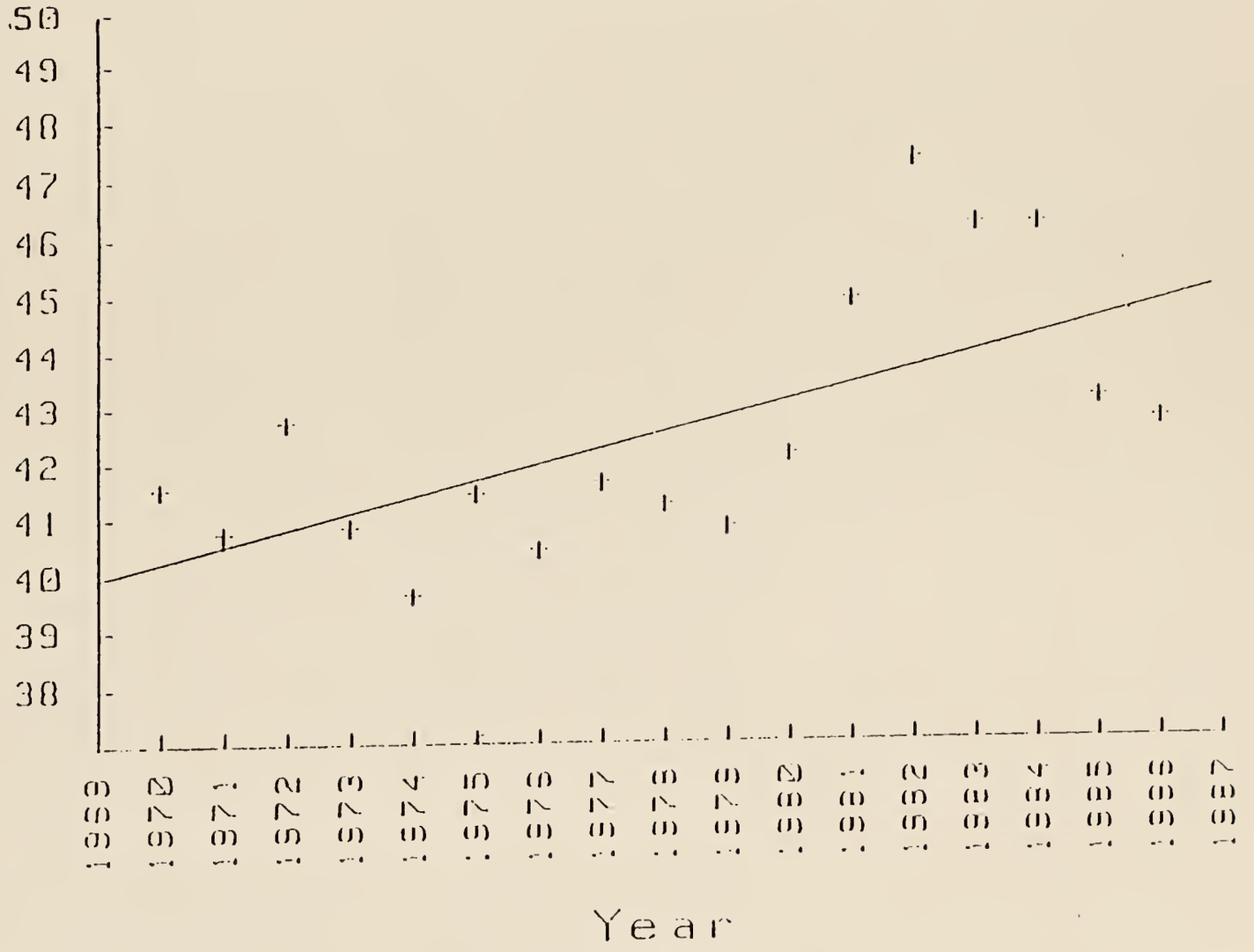
U.S. Children Under 18 Years of Age Living Below the Poverty Level, by Race and Ethnicity, 1975, 1980, 1987



Source: Prepared by Policy Research Incorporated based on data included in: U.S. Bureau of the Census. Statistical Abstract of the United States: 1989 (109th edition). Washington, DC, 1989, Table 738, p. 454

Figure 2.4.4

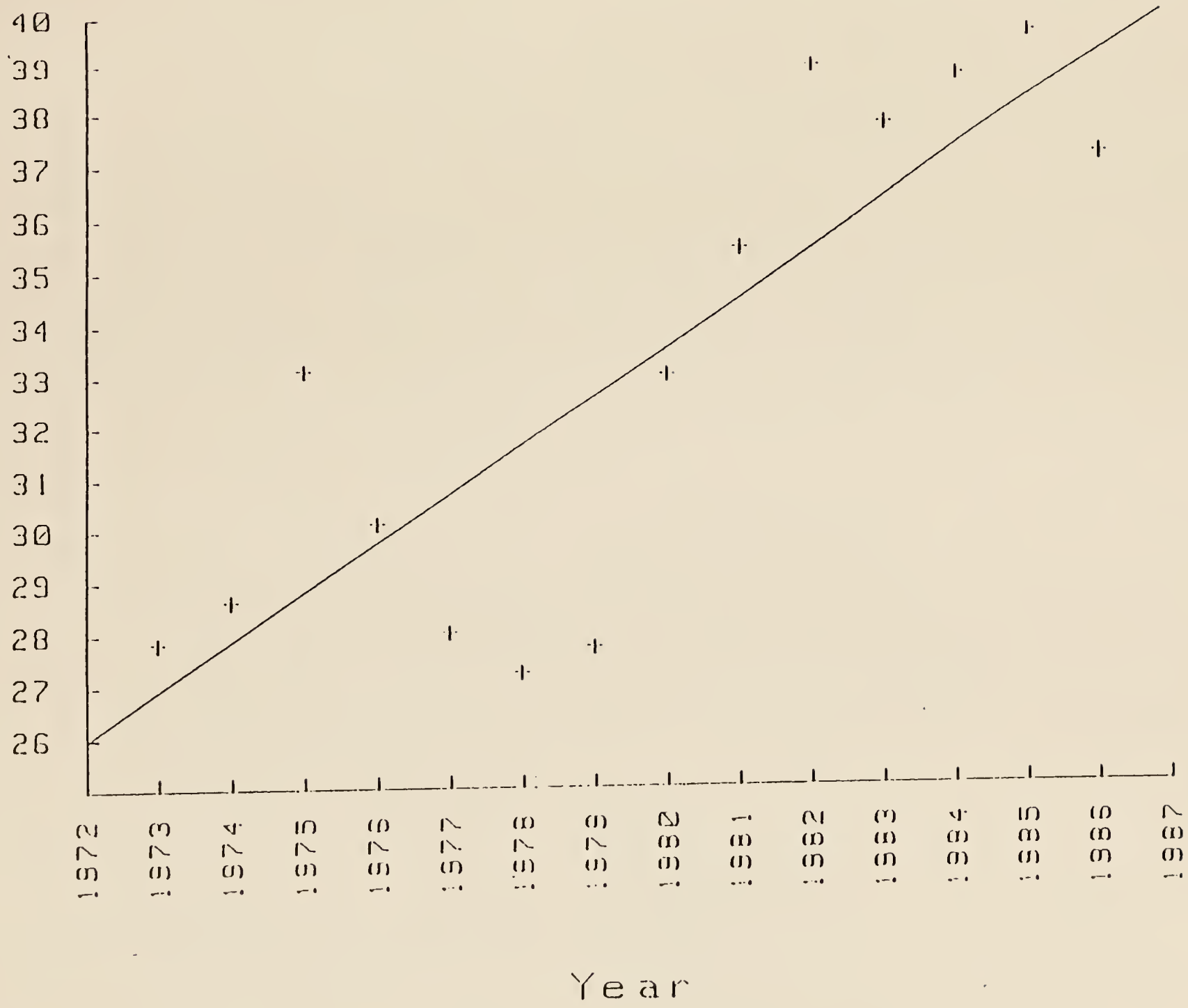
Black Children Living Below the Poverty Level: United States, 1969-1986



Source: Prepared by Policy Research Incorporated based on data from Table 2.4-8

Figure 2.4.5

Hispanic Children Living Below the Poverty Level: United States, 1969-1986



Source: Prepared by Policy Research Incorporated based on data from Table 2.4-8

PART THREE:

THE HEALTH STATUS OF ADOLESCENT MINORITY MALES

3.1 OVERVIEW TO PART THREE

The poor health status of many minority adolescent males begins at birth or before birth. Premature birth or low birth weight are disproportionately high among minority infants, and they are further exacerbated by poor nutrition and inadequate postnatal care. Many young mothers have neither the emotional nor financial support from a spouse with whom they share child-rearing responsibilities. Growing up in substandard housing, low-income males are susceptible to the long-term deleterious effects of lead poisoning, as well as to a host of other maladies such as respiratory problems, infestation from lice and other vermin, and bites from rats and insects. Finally, many children in low-income families grow up without access to the health care generally available to other children; this includes regular annual pediatric examinations, periodic visits to a dentist, screening for chronic and acute diseases, and adequate treatment for illness.

This section reviews the health status of minority males during their adolescence, focusing on the major physical health and mental health problems of this group. In contrast to infectious and chronic diseases, caused by biological factors, the most common causes of mortality and morbidity among adolescent minority males stem from social, cultural, and economic forces that foster behaviors which are both self-destructive and harmful to others. For all adolescent males, the leading causes of mortality are homicides, accidents and suicides. Among minority males in the 15-24 age group, these three categories account for 75% of all deaths. Among young Black males ages 15 to 24, homicide is the leading cause of death and accounts for 42% of all deaths; in real numbers, in 1986, 2,435 Black males ages 15 to 24 were victims of homicide. Disturbingly, the homicide rate among adolescent Black males increased 39% between 1984 and 1987. Regional studies suggest that Hispanic males have similarly high homicide rates.

Suicides are also a leading cause of death among adolescents. Suicides rates among Black males 15-24 have tripled since 1960. Among American Indian adolescent males, suicide rates are twice the national rate, accounting for 17% of all deaths in 1984-1985. Recent studies of Hispanic adolescents suggest an alarming increase in the number of suicides in certain regions in the United States during an 18 month period in 1988 and 1989.

Fatalities from gunshot wounds, pedestrian accidents, drownings, and fire-related accidents are significantly higher among adolescent Black males, and particularly younger adolescent Black males 10 to 14, than among White males of the same ages. The proportion of all injuries suffered at school and at home is significantly higher for Black adolescents, compared to White adolescents.

While data are not wholly conclusive, one common thread connecting increased death and disability resulting from violence is the use and abuse of alcohol and other drugs. Although national surveys yield conflicting findings with respect to adolescent minority substance abuse, some data sources indicate that minority adolescents are disproportionately at risk. Data from drug-related hospital admissions and drug treatment programs, along with drug-related mortality statistics, show an overrepresentation of minority adolescent males. Household surveys, which are known to underestimate illicit drug use, have shown comparable levels of marijuana use among all racial and ethnic groups of young adults (18 to 24), but a significantly greater incidence of heroin use among Black males.

With respect to the abuse of alcohol, studies are inconclusive regarding the extent of use among Black and Hispanic male adolescents. Among Native American adolescents, however, alcohol abuse is a very serious problem with staggering social and economic consequences. Rates of alcohol use and alcoholism among Native American males ages 15 to 24 are several times higher than for the general population, and liver cirrhosis is the ninth leading cause of death among this population. Between 1984 and 1985, death rates attributed to alcoholism were six times higher among adolescent Native American males compared to death rates for their age mates in the U.S. population as a whole. In one study, almost 20% of all 7th-12th grade Native Americans were classified as heavy drinkers.

The newest and most dangerous threat to the health of young minority males is the human immunodeficiency virus (HIV), which was the sixth leading cause of death among Black males 15-24 in 1987. National data show that mortality rates from HIV infection among Black males 15-24 are three times higher than the rates among their White counterparts. Minority youth are disproportionately represented among cases of acquired immunodeficiency syndrome (AIDS); by January, 1990, 29% of male cases in the 13 to 19 age group were Black and 18% were Hispanic. Surveys indicate that minority adolescents are less informed about AIDS compared to their White counterparts, and also that they perceive themselves to be less at risk from HIV infection.

The prevalence of sexually transmitted diseases (STDs) among adolescents is a strong indicator of unsafe sex practices and thus an indicator for HIV seroprevalence. Centers for Disease Control (CDC) rates for syphilis and gonorrhea are substantially higher among minority adolescents, compared to White adolescents. In 1988, the prevalence of syphilis among Black and Hispanic males ages 15 to 19 was 58 times and 22 times, respectively, higher than rates for White males in the same age group. Although data on STDs are not available for Native American adolescents, high syphilis infection rates have been documented among adult Native Americans. Higher rates of STDs and IV drug use, especially in the inner-cities, are primary reasons why Black and Hispanic males are

disproportionately represented among the adolescent AIDS cases and deaths.

In other areas of preventive health, minority adolescents are in poorer health compared to their White counterparts. With regard to smoking, national and regional studies have shown that both smoking prevalence and smoking onset rates are higher among minority adolescents; young Hispanic males are especially at risk for smoking initiation. As to nutritional status, poor nutrition among Hispanic and Native American adolescents is associated with a risk of stunted growth and an excess prevalence of overweight. Nationwide dental health surveys show that minority adolescents have poorer dental health and more unmet dental needs, compared with Whites of the same age.

Available mental health studies indicate that specific mental health needs differ among various ethnic and racial adolescent populations and that low socioeconomic status is a strong risk factor for certain adolescent mental health problems. For example, in one study, the rate of serious depression among low-income Black adolescents was as high as 15%. Another study concluded that among Native American adolescents, depression, suicide, low self-esteem and alcohol and other drug abuse are the most serious mental health problems. A group that is often neglected with respect to mental health needs is Asian-American adolescents. Studies have shown that Asian-American students, for example, experience major adjustment problems in college. Newly arrived Southeast Asian refugee adolescents have high levels of depression and other disorders stemming from their traumatic immigration and resettlement experiences. Asian-Americans overall tend not to utilize mental health services, although the data suggest that many have high levels of disturbances. In general, minority adolescents are more likely to experience problems of access to mental health care because of institutional, cultural, language, and economic barriers.

Tuberculosis, hypertension, chronic respiratory problems, and lead poisoning are diseases and syndromes more commonly found among minority adolescents. More specifically, Black males ages 15 to 24 are four times as likely to contract tuberculosis, a preventable disease associated with crowded conditions and poor health care, compared to White males of the same age. The National Health and Nutrition Survey II (NHANES II) estimated that 18% of poor Black children had blood lead levels above the toxic level, compared to 4% of all American children. Inadequate preventive health care, poor environmental conditions, substandard housing and unsanitary conditions have all been associated with these chronic and acute health problems that disproportionately afflict minority adolescents.

As children in low-income families, many minority adolescent males grow up with little access to health care services. Results

from a nationwide survey indicate that almost one-fifth of all Black adolescents and one-third of all Hispanic adolescents were uninsured in 1984. The importance of health insurance coverage, particularly Medicaid coverage, in equalizing health care service use for low-income adolescents is well documented. For instance, an analysis of health care utilization patterns indicated that Black and Hispanic adolescents were less likely to visit a physician annually even though they reported being in poorer health compared to their White counterparts, but that the discrepancy was less for those with health insurance.

In addition to financial barriers to health care service utilization, barriers imposed by provider limitations also render minority adolescents at risk of not obtaining necessary health services. Many physicians are ill-equipped to deal with the problems that minority youth present and, in addition, language and cultural barriers inhibit effective communication and appropriate health care and referral services.

Part 3 of this report presents available data related to the health status of minority adolescent males. Section 3.2 describes the trends and nature of mortality among three adolescent minority populations: Black, Hispanic and Native American. The contribution of firearms to adolescent mortality from homicide and suicide is also examined. Section 3.3, Preventive Health, addresses personal health habits among adolescent males, including smoking, nutritional status, and dental health. The same section also discusses sexually transmitted diseases, including HIV infection.

Section 3.4 addresses acute and chronic diseases, including tuberculosis, hypertension, diabetes, chronic respiratory problems, lead poisoning and sickle-cell anemia. Limitations of activity as a result of chronic conditions are compared among adolescents by racial group and socioeconomic status. In the section, the mental health needs of minority adolescents are analyzed to the extent possible, based on the limited number of relevant studies of Black, Mexican-American, Native American, and Southeast Asian adolescents.

Since alcohol and other drug abuse are the most salient preventable risk factors associated with excess mortality among minority adolescents, substance abuse is treated separately in Section 3.5. In analyzing the extent of alcohol and other drug abuse among minority adolescent males, various data sources were utilized, including household surveys, drug-related mortality statistics, emergency room admissions, and data from drug-treatment programs.

3.2 MORTALITY

3.2.1 Overview

This section describes the nature and trends of adolescent mortality in three U.S. minority populations: Black, Hispanic, and Native Americans. When possible, the mortality rates are compared to the rates for the majority White population or the U.S. population as a whole. Time trends are analyzed, as well as the contribution of various causes of death to total adolescent mortality. International comparisons are also presented, demonstrating that some aspects of the mortality experience of adolescents in the United States, especially minority adolescents, are unique.

For adolescent and young adult males in all racial and ethnic groups between the ages of 15 and 24, accidents and violence are the leading causes of death, and together they account for over three-fourths of all deaths in this group.[1] In contrast, overall mortality for most diseases among all adolescents is lower than for other age groups. While adolescent deaths from diseases declined significantly between 1950 and 1987, there has been a marked increase in adolescent deaths caused by violence, especially among 15- to 24-year-old males.

Data regarding adolescent mortality for other minority populations, such as Chinese-, Japanese-, and Hawaiian-Americans, are limited. Even with the available mortality statistics, it is difficult to isolate data for ages 10 to 24 years, the population of concern for this report. Detailed published mortality statistics are available only for age groupings of 10 to 14 years, 15 to 19 years, and 20 to 24 years. Much of the published data and analyses deal with 15 to 24 year olds, reflecting the experience of older adolescents and young adults. As for Hispanic adolescents, the National Center for Health Statistics (NCHS) does not routinely calculate Hispanic mortality rates. Smaller regional studies, often out of date, must be utilized to estimate Hispanic death rates. Native American mortality data are also limited, including only those living in Reservation States. Unfortunately, the possible role of genetics in contributing to different adolescent mortality experiences is not well understood and difficult to substantiate.

3.2.2 Life expectancy

Before discussing the mortality experience of adolescent males, it is worthwhile to examine life expectancy trends at birth and at age 21. For the American male population in general, there has been a steady increase in life expectancy at birth at least since 1950, as indicated by Figure 3.2.1. While this has been true for Black males as well, there remains a seven-year disparity in life expectancy at birth between Black and White males; in 1987,

the average life expectancy at birth was 72.2 for White males and 65.2 for Black males.[2] In fact, life expectancy at birth has actually decreased or remained steady for Black males since 1984, when it was 65.6 years.[3]

In 1987 (the most recent year for which data are available), remaining life expectancy at age 21 was 51.7 years for White males, compared to 45.5 years for Black males of the same age - a 6.2 year disparity.[4] Among the 10 leading causes of death for adolescents, only the rates for motor vehicle accidents and suicides were higher among White adolescents in all three five-year age categories (10 to 14, 15 to 19, 20 to 24) compared with Black youth in the same categories.[5] The difference in life expectancy between Black and White males at age 21 has worsened since the mid-70s, when it decreased by 5.0 years (see Figure 3.2.2). Thus, at age 21 males have significantly different life expectancies according to their racial background.

3.2.3 Mortality Among Black Adolescents and Young Adults

Relative to other age groups, adolescent mortality rates are very low. There are several important patterns in adolescent death rates however, among adolescents as well as the general population. Death rates are higher for males than for females; death rates are significantly higher among older adolescents compared to younger ones; and death rates are higher among minority adolescents than among White adolescents.

For males ages 10 to 24, the nature and rate of mortality undergo marked changes with age. In 1987, mortality rates for Black males ranged from 46.1/100,000 for ages 10 to 14 to 203.9/100,000 for ages 15 to 24 years, a four-fold difference (Tables 3.2.1 and 3.2.2). This difference is explained primarily by the difference in deaths caused by homicide, accidents, and suicide. In 1987, the death rate for homicide (including legal intervention, i.e., death as a result of police action) was 6.8/100,000 among Black males ages 10 to 14 years old but 85.6/100,000 among Black 15 to 24 year olds, a 13-fold difference.

At ages 10 to 14 years, the Black-White mortality ratio in 1987 was 1.4, meaning that Black adolescents in this age group were 40% more likely than Whites to die from all causes (see Table 3.2.1). The racial disparity in adolescent male mortality rates increases with age. For ages 15 to 24, the Black-White mortality ratio was 1.5 (see Table 3.2.2). The 50% higher Black mortality rate is due to the high occurrence of homicides among Black youth in this age group.

Table 3.2.1 compares the five leading causes of death in 1987 for young adolescent White and Black males ages 10 to 14. For both races, unintentional injuries ("accidents and adverse effects") are the leading cause of death, accounting for 55% of all deaths among

Whites and 46% among Black adolescents. There are marked racial differences among the remaining causes of adolescent death: for Black adolescents, the second leading cause of death for this age group is homicide, while for White adolescents it is malignant neoplasms. Homicide accounts for 15% of all deaths among 10 to 14 year old Black adolescents, compared to 3% of deaths among their White counterparts. Suicide is not a leading cause of death for Black adolescents, but is the third leading cause among White youth of the same age, accounting for 8% of deaths among young White males.

The rates and the nature of mortality among 10 to 14 year olds are indicators of adult morbidity and mortality. For instance, young Black males have higher chronic obstructive pulmonary disease (COPD) and heart disease mortality rates compared to their White counterparts.

Table 3.2.2 lists the leading causes of death for older adolescents and young adults 15 to 24 years of age. Overall mortality rates among Black males ages 15 to 24 are significantly higher than for their White male counterparts. Although the racial mortality differential steadily decreased between 1970 and the early 1980s, it increased between 1983 and 1987. While mortality rates for White males ages 15 to 24 remained relatively steady between 1983 and 1987, mortality rates for Black male adolescents and young adults increased substantially during that time (see Table 3.2.3). For instance, mortality rates for all causes among White ages 15 to 24 stayed within the range of 136/100,000 to 146/100,000 during 1983-1987, while among same-age Black adolescents and youth, the all-cause mortality rate increased from 165/100,000 in 1983 to 204/100,000 in 1987.

Different mortality patterns among Black and White adolescent and young adult males are evident in Table 3.2.2. For White males ages 15 to 24, the five leading causes of death, in order of magnitude are: unintentional injuries, suicide, homicide, malignant neoplasms, and diseases of the heart. For Black males of the same age, the leading causes of death differ in magnitude and in order of importance. The five leading causes of death for adolescent Black males are: homicide, unintentional injuries, suicide, diseases of the heart, and malignant neoplasms. Of the five leading causes of death among males 15 to 19, only mortality rates from unintentional injuries other than motor vehicular and from malignant neoplasms were essentially the same, comparing between Black and White adolescents. Mortality rates from the other leading causes of death exhibit marked differences by race. For instance, motor vehicle and suicide mortality rates are more than one and a half times as high among White males 15 to 24, compared with their Black counterparts. Similarly, homicide and diseases of the heart rates for Black males are 7.6 times and 2.3 times higher, respectively, than rates for White males of the same age.

Figure 3.2.3 also indicates that White and Black adolescent and young adult males have remarkably different mortality experiences. Homicide is the leading cause of death for young Black males ages 15 to 24 and was responsible for 42% of all deaths in this age group in 1987. In real numbers, of the total 6,194 young Black males who died in 1986, 2,435 died of homicide.[6] In contrast, homicides are the third leading cause for young White males and only accounted for 8% of all deaths among this group in 1987. Although there was an overall decrease of 40% in the homicide rate among 15 to 24 year old Black males between 1970 and 1984, the homicide rate increased 39% between 1984 and 1987 (see Table 3.2.3). The homicide rates for younger Black males ages 15 to 19 and for Black males ages 20 to 24, within this 10 year age group, exhibit appreciable differences. Between 1984 and 1987, the homicide rate for Black males ages 15 to 19 rose more than 50%--from 39.3/100,000 to 60.0/100,000.[7] The homicide rate among Black males ages 20 to 24 also increased between 1984 and 1987 but by a relatively smaller margin; for this older group, the rates increased by 33% from 84.5/100,000 to 112.6/100,000.[8]

The role played by drug-related activities in the increase of homicide rates among young Black males during the mid 1980s is difficult to determine. The major reason is that there is no uniform definition for drug-related deaths -- for instance, while some law enforcement offices use the strictest criteria for defining a drug-related death, i.e., drugs found on the victim, other offices use broader criteria including economic motives (robbery) and systemic motives (violence intrinsic to involvement with any illicit substance).[9] Therefore, actual records of drug-related homicides, in as far as they are kept, vary from area to area. The Uniform Crime Reports (UCR), collected by the FBI and comprising the most publicized source of crime data in the country, contain aggregate data of crimes known to the police. However, it is impossible to link specific homicides to antecedent drug activities of either the victim or perpetrator.[10] The major alternative criminological data source is the National Crime Survey (NCS). Issued by the Bureau of Justice Statistics, the NCS uses the household as its basic sampling unit. As with the UCR, the NCS is not useful as a single source for arriving at valid, correct estimates of drug-related homicides.

Although the relationship between drugs (especially crack and cocaine) and homicide has been widely reported in the popular press, a paucity of evidence exists to document this phenomenon. Only recently have efforts been made to assess this problem on a national level.[11] [12] The following data from various sources suggest that the increase in homicides among young Black males is related to an increase in drug-related activities; for example, the percentage of murders that were narcotics-related on a national basis increased from 2.7% in 1984 to 5.6% in 1988.[13]

A report on Drug Abuse and Crime in the District of Columbia found that "the highly addictive crack cocaine has spurned a network of open air drug markets that have been focal points for much of the drug-related violence."[14] In Washington, D.C. (the District), the number of juvenile arrests for sales and possession of heroin/cocaine increased by factors of 56.7 and 4.4, respectively, between 1984 and 1988. By 1988, the report found that the overwhelming majority of juvenile arrests in the District (68%) were for the sale of heroin or cocaine. An analysis of drug offenses and homicides in the District indicated that the majority of homicides occurred in the areas of the city where the greatest amount of drug activity took place. Furthermore, in 1988 there was a record number of homicides in the District (369), of which 80% of the cases were drug-related. Further discussion of the dramatic increase in homicide rates among young Black males is presented in Section 3.6 -- Injuries.

The leading cause of death for White males ages 15 to 24, and the second leading cause for Black males in the same age group, is unintentional injuries. Vital statistics coding distinguishes unintentional from intentional injury deaths. Intentional injury deaths are defined as deaths due to suicide and homicide, including homicide resulting from legal intervention; unintentional injuries are all other "accidents and adverse" deaths. A 1983 literature review on unintentional injuries among adolescents and young adults suggests that male gender and alcohol and other drug abuse are important contributing factors for accidents.[15]

Although the adolescent White-Black mortality-rate ratio for suicide in 1987 was 1.8 (Table 3.2.2), there is substantial concern about the increasing suicide rate among young Black youth.[16] The suicide pattern among Black adolescents differs from that of their White peers. While White suicide rates increase with age, suicide peaks among youthful Black Americans and declines in middle age.[17] Table 3.2.3 reveals that the suicide rate among Black adolescent and young adult males has more than doubled between 1950 and 1987. Since the majority of the increase occurred between 1960 and 1970 when there was a change in the population base on which the rates were calculated,[18] these data must be interpreted cautiously. Among Black youth ages 15 to 24, the suicide rate nearly tripled between 1960 and 1984.[19]

In addition to homicides, motor vehicle accidents, and suicides, deaths from acquired immunodeficiency syndrome (AIDS) have become a major cause of death among minority adolescent males. In 1987, Human Immunodeficiency Virus Infection (HIV) was the sixth leading cause of death among Black adolescent males ages 15 to 24. For the overall population in that age group, HIV-related deaths ranked seventh. Before 1987, death from HIV infection was assigned to one of several categories rendering difficult the analysis and comparison of AIDS mortality over time. A new category for coding HIV deaths was introduced in 1987. Using this new coding system,

the death rate for HIV infection among Black males ages 15 to 24 was calculated as 5.3/100,000, compared to 1.8/100,000 among White males in the same age group.[20] Thus in 1987, Black adolescent and young adult men were three times as likely to die from AIDS compared to their White counterparts. (Further discussion on reported AIDS cases and HIV prevalence among minority adolescents can be found in Section 3.3.)

In summary, unintentional injuries and violence accounted for over three fourths of all adolescent and young adult deaths among Black Americans in 1987. In real numbers (using 1986 data), this means that 4,684 young Black youth died from unintentional injuries, homicides and suicides. Assuming that these mortality rates remain at the 1986 levels and do not increase annually (as they have for homicides and motor vehicle accidents in the past four years), a rough estimate is that over 50,000 young Black males will die in the next decade from these tragic, and in many cases preventable, causes of death. Further discussion on the issue of violence in relation to injuries and death among adolescent males is presented in Section 3.6.

Ironically, while the death rate due to violence has increased among young Black males, the "natural" leading causes of death, e.g., heart disease and malignant neoplasms, both decreased dramatically between 1950 and 1987. Heart disease decreased by a factor of 2.6, while malignant neoplasms decreased by a factor of 1.2 (Table 3.2.3).

3.2.4 Mortality Among Adolescent Hispanic Americans

No comprehensive published analysis of mortality among U.S. Hispanics was identified, and national mortality rates for Hispanics as a specific subgroup are not available. Only the raw numbers of deaths for various causes are routinely published for Hispanics and even this information has been collected only since 1984. In studying the Hispanic adolescent, it is important to remember that the designation Hispanic comprises diverse ethnic and cultural subgroups (see Introduction for further discussion).

Table 3.2.4 presents the percent distribution of each of the leading five causes of death for adolescent Hispanic males ages 15 to 24. These data are based on deaths of residents of 18 reporting states and the District of Columbia. For comparative purposes, White and Black adolescent and young adult death distributions by cause in three of these areas are also presented (see Figure 3.2.3). Unintentional injuries were the leading cause of death among young Hispanic males, accounting for 45% of deaths in 1986. Homicide and legal intervention accounted for 29% of deaths, followed by suicide, responsible for 9% of deaths. Injuries and violence together accounted for 83% of all young male Hispanic deaths.

Marked differences in the distribution of mortality by cause are evident among the Hispanic subgroups presented in Table 3.2.4. For two of the four subgroups, South and Central American and Puerto Rican Hispanics, homicide comprises the largest number of deaths, one third or more. Proportionally, there are about six times as many homicide deaths among adolescent males in these two subgroups compared to homicide deaths among White males in the same age group. Puerto Rican adolescent males have the smallest percentage of deaths attributed to unintentional injuries, followed by Cuban, South and Central American, and finally, Mexican-Americans. Half of all Mexican-American deaths among males ages 15 to 24 are caused by unintentional injuries and one-third by motor vehicle accidents. Notably, the contribution of suicide to overall mortality is similar among all Hispanic subgroups. The percent of total deaths due to suicide among the four Hispanic subgroups is approximately 9%, falling between the Black and White figures.

Although understanding the percent distribution of the leading causes of death is important in analyzing mortality trends, the availability of cause-specific mortality rates is critical in evaluating the severity of the problem. Since national data on Hispanic mortality rates are unavailable, regional studies are often used to study the incidence of mortality among the Hispanic adolescent community.

The most current study available focused on the five southwestern states where 60% of all Hispanics in the United States reside; of whom, 85% are Mexican American.[21] Data were obtained on all suicides and homicides among young adult Hispanics and Anglos from 1976 to 1980. The term Anglo is used in this section instead of the term White because Anglo specifically refers to White persons who are not Hispanic. The most striking finding of this study is the extremely high homicide rates among Hispanic males that peak at a rate of 80/100,000 in the 20 to 24 year old age group.[22]

For suicide, the general pattern among young males in both ethnic groups is similar, with one of the highest suicide rates in the 20 to 24 year old age group (although the rate is much lower than for homicide). Significantly, Hispanic and Anglo suicide rates among adolescent and young adult males were about the same from 1976 to 1980. Suicides among Hispanics are discussed further in Section 3.6 --Injuries. According to a paper presented at the annual meeting of the American Public Health Association in 1989, as of that year no original research had been published on suicides among Latino children or teenagers.[23]

3.2.5 Mortality Among Adolescent Native Americans

Adolescent Native Americans have mortality experiences similar to their non-Indian minority counterparts: high mortality due to

injuries; violent and risky behavior manifested in high mortality from homicides; and high rates of suicides associated with substance abuse and depression. It must be noted that there is no universal Native American culture but rather tremendous diversity among tribes and geographic locations. At the same time, many Native American adolescents share economically depressed living conditions. They frequently live on or near reservations characterized by high unemployment, a high rate of violence, poor housing and poverty. These conditions are reflected in the fact that overall, Native Americans are 1.7 times more likely to die in their adolescent and young adult years compared to all other races at the same age.[24]

Table 3.2.4 shows selected leading causes of death for young Native American males. The leading causes of death (injuries, suicides and homicides) are the same for Native American adolescents and other adolescents. The difference in mortality rates is primarily due to the substantially greater magnitude of each of these causes among Native American adolescents (Figure 3.2.3). Unintentional injuries are the leading cause of death among adolescent and young adult male Native Americans, accounting for almost two-thirds of all deaths between 1984 and 1986.[25] Although motor vehicle deaths are commonly associated with young White males, adolescent and young adult Native American males die from motor vehicle accidents at a rate 1.6 times that of the U.S. all races population. The combination of rural living, poor roads, and heavy drinking[26] may be responsible for increased automobile fatalities.

Unintentional injuries, suicides and homicides accounted for 87% of all deaths among male adolescent Native Americans in 1984-1986.[27] This is higher than for any other racial/ethnic minority in the United States. Since the median age of the Native American population is 17 years, a large portion of the Native American population falls within this vulnerable age group.

The suicide rates among Native American adolescents are particularly dramatic. The average suicide rate for 1984 to 1986 among adolescent and young adult male Native Americans was 40.9/100,000 -- 1.9 times the rate for the nation as a whole and 3.5 times the rate for adolescent Black males in 1986. Comparable figures for 1980-1982 among Native Americans ages 10 to 14 indicate even more disparity between Indian and non-Indian youth suicide rates.[28] The vast majority of Native Americans who attempt suicide are under age 25; almost half are under age 20.[29] Considering that suicide rates are generally underestimated, especially among minority populations,[30] it is especially disturbing that suicide causes 17% of all Native American deaths among young males.[31] (Suicide among Native American adolescents is discussed further in Section 3.6 -- Injuries.)

Data from the Indian Health Service indicate that Native American adolescent males die from alcoholism at a rate six times that of the general U.S. population (all races).[32] Alcoholism was among the ten leading causes of death for Native American adolescents and young adults from 1984 to 1986.[33] The disparity in alcoholism death rates between Indians and non-Indians at this young age continues into the adult years.

3.2.6 Firearms and Mortality among Adolescent Minority Males

Increased attention has been focused on the contribution of firearms to adolescent mortality from homicide, suicide and unintentional injury. This attention was sparked by recent comparisons of U.S. adolescent mortality to that of other industrialized countries.[34] [35] These analyses indicated that while death rates for natural causes (i.e., diseases) showed little cross-national variation, U.S. death rates for external causes (i.e., injuries, homicide and suicide) ranked highest.[36]

It is noteworthy that during the 1980s, suicides committed using firearms accounted for steadily increasing proportions of all Black teenage male suicides -- from 52% in 1982 to 71% in 1987.[37] Figure 3.2.4 indicates that from 1977 and 1987, the rate of nonfirearm suicide among Black males ages 15 to 19 remained stable while the rate of firearm suicide more than tripled. (Note that a logarithmic scale is used for the y- axis of Figure 3.2.4.) Other studies show that the 30-year climb since 1950 in suicide mortality in the 15- to 24-year age group is paralleled by a 30-year increase in firearm suicides.[38] Fingerhut and Kleinman[39], have shown that for Black male teenagers, 40.8% of all teenage deaths were associated with firearms, compared with 16.2% among White males. Furthermore, firearms have been responsible for 75% to 80% of all Black male teenage homicides since 1968.

The gap between firearm and nonfirearm homicides among Black males ages 15 to 19 has doubled in the last two decades.[40] Ominously, both firearm homicide and firearm suicide mortality among this group have shown sharp and steady increases since 1984. From 1984 to 1986, firearm fatalities among Black males ages 15 to 24 increased by 20%.[41] Proliferation of civilian[42] firearms may have had especially severe repercussions for young Black males since violence accounts for half of all deaths among this group. It is logical to assume that the increasing availability of firearms also plays a role in the escalating homicide and suicide rates among other minority adolescents. Death rates from unintentional injuries other than motor vehicular, suicides, and homicides among Native American male adolescents are 2.5, 1.9, and 1.7 times, respectively, as high compared to their U.S. counterparts of all races.

Table 3.2.1

Leading 5 Causes of Death (per 100,000 population) for Adolescent Males
Ages 10-14 by Race: United States, 1987

White Males			Black Males		
Cause of Death	Death Rate	Percent	Cause of Death	Death Rate	Percent
Accidents and Adverse Effects	18.0	55	Accidents and Adverse Effects	21.4	46
Motor Vehicle	10.8	33	All Other	13.5	29
All Other	7.2	22	Motor Vehicle	7.9	17
Malignant Neoplams	3.6	11	Homicide & Legal Intervention	6.8	15
Suicide	2.5	8	Diseases of Heart	2.4	5
Congenital Anomalies	1.1	3	Chronic Obstructive Pulmonary Disease and Other Allied Conditions	2.3	5
Homicide & Legal Intervention	1.0	3	Malignant Neoplasms	2.2	5
All other	6.6	20	All other	11.0	24
All Causes	32.8	100	All Causes	46.1	100

Source: National Center for Health Statistics. Vital Statistics of the United States, 1987, Vol. II, Mortality, Part A. PHS. Washington, DC: U.S. Government Print Office

Table 3.2.2

Five Leading Causes of Death (per 100,000 population) for Adolescent Males
Ages 15-24 by Race: United States, 1987

White Males			Black Males		
Causes of Death	Death Rate	Percent	Cause of Death	Death Rate	Percent
Accidents and Adverse Effects	77.3	56	Homicide & Legal Intervention	85.6	42
Motor Vehicle	59.2	43	Accidents & Adverse Effects	58.1	28
All Other	18.1	13	Motor Vehicle	36.2	18
Suicide	22.7	16	All Other	21.9	11
Homicide & Legal Intervention	11.2	8	Suicide	12.9	6
Malignant Neoplasms	6.0	4	Diseases of Heart	6.9	3
Diseases of Heart	3.0	2	Malignant Neoplasms	6.5	3
All other	17.1	14	All other	33.9	18
All Causes	137.3	100	All Causes	203.9	100

Source: National Center for Health Statistics. Vital Statistics of the United States, 1987, Vol. II, Mortality, Part A. PHS Washington, DC: U.S. Government Printing Office

Table 3.2.3

Leading Causes of Death (per 100,000 resident population) for Male Adolescents Ages 15-24, by Race: United States, 1950-1987

	All Causes		Motor Vehicle Accidents		Homicide and Legal Intervention	
	White	Black	White	Black	White	Black
1950*	152.4	289.7	58.3	41.6	3.7	58.9
1960*	143.7	212.0	62.7	46.4	4.4	46.4
1970	170.8	320.6	75.2	58.1	7.9	102.5
1980	167.0	209.1	73.8	34.9	15.5	84.3
1983	137.0	165.0	57.0	28.3	11.5	66.8
1984	138.8	163.9	59.1	31.9	11.1	61.5
1985	136.3	174.1	57.4	32.1	11.2	66.1
1986	145.9	190.5	62.6	35.3	12.5	79.2
1987	137.3	203.9	59.2	36.2	11.2	85.6

	Suicide		Malignant Neoplasms		Diseases of Heart	
	White	Black	White	Black	White	Black
1950*	6.6	4.9	9.9	7.9	5.8	18.0
1960*	8.6	4.1	10.3	9.7	3.6	8.7
1970	13.9	10.5	10.6	9.4	3.0	8.3
1980	21.4	12.3	7.8	8.1	2.9	8.3
1983	20.6	11.5	6.7	5.6	2.7	6.6
1984	22.0	11.2	6.8	6.4	2.8	6.7
1985	22.7	13.3	6.5	6.4	3.0	7.2
1986	23.6	11.5	6.8	6.3	3.0	6.7
1987	22.7	12.9	6.0	6.5	3.0	6.9

* Includes deaths of non-residents of the United States.

Source: National Center for Health Statistics. Vital Statistics of the United States, 1986, Vol. II, Mortality, Part A. DHHS Pub. No. 87-1122. PHS. Washington, DC: U.S. Government Printing Office; 1989

Table 3.2.4
Leading 5 Causes of Deaths for Adolescent Males Ages 15-24 Years:
Total of 18 Reporting States and District of Columbia, 1986

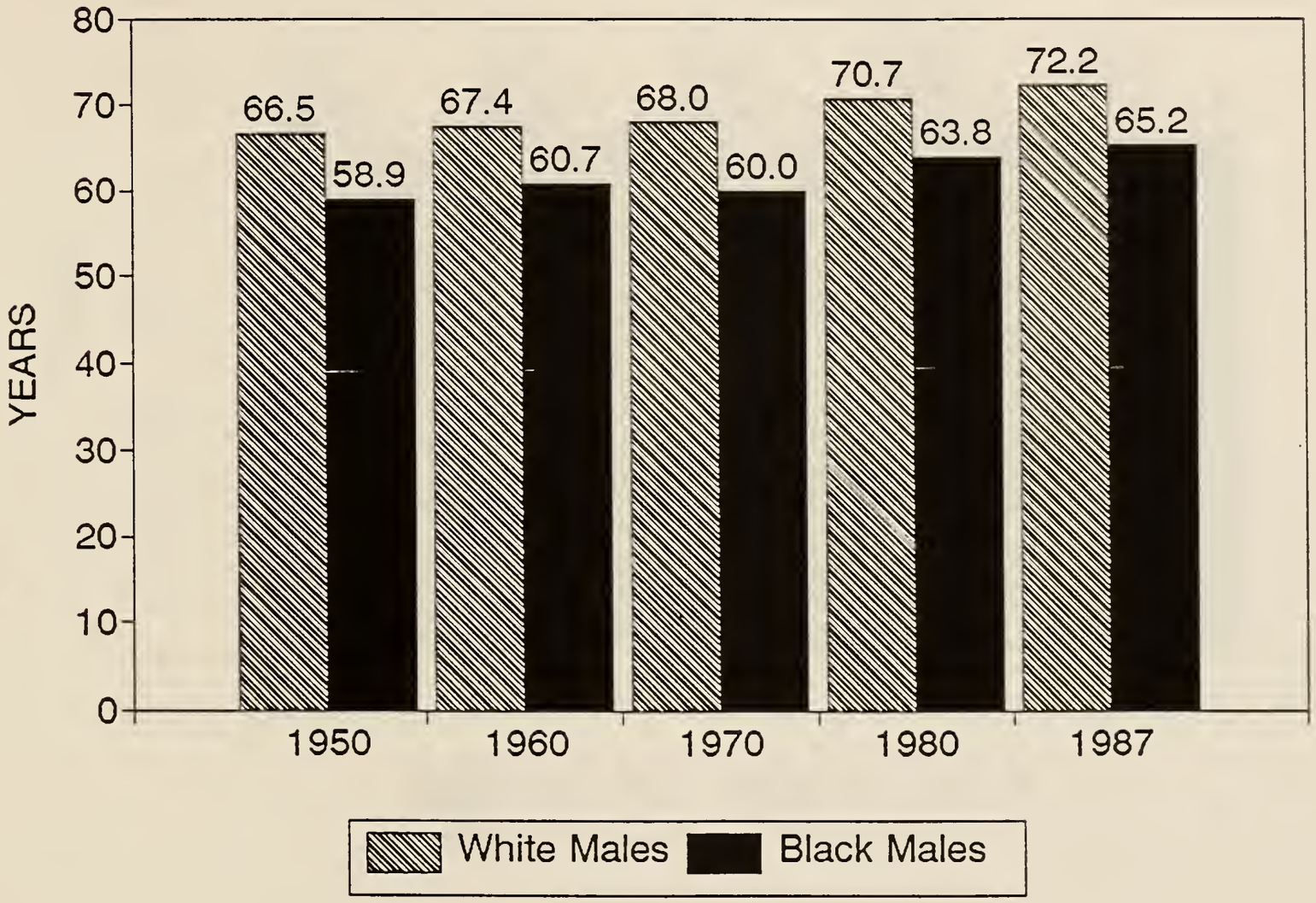
	Percent of Total Deaths							
Cause of Death	Hispanic	Mexican	Puerto Rican	Cuban*	South & Central Am.	White	Black	Native Am
Accidents	45	49	28	33	35	57	27	55
Motor vehicle	30	34	11	21	24	44	16	35
Homicide	29	28	33	24	37	6	45	13
Suicide	9	9	8	9	7	17	6	16
Malignant Neoplasms	3	3	2	3	6	5	3	2
Diseases of Heart	1	1	2	3	0.5	2	3	

*Total of 33 Deaths

Source: National Center for Health Statistics. Vital Statistics of the United States, 1986, Vol. II, Mortality, Part A. DHHS Pub. No. 87-1122 PHS. Washington, DC: U.S. Government Printing Office; 1989

Figure 3.2.1

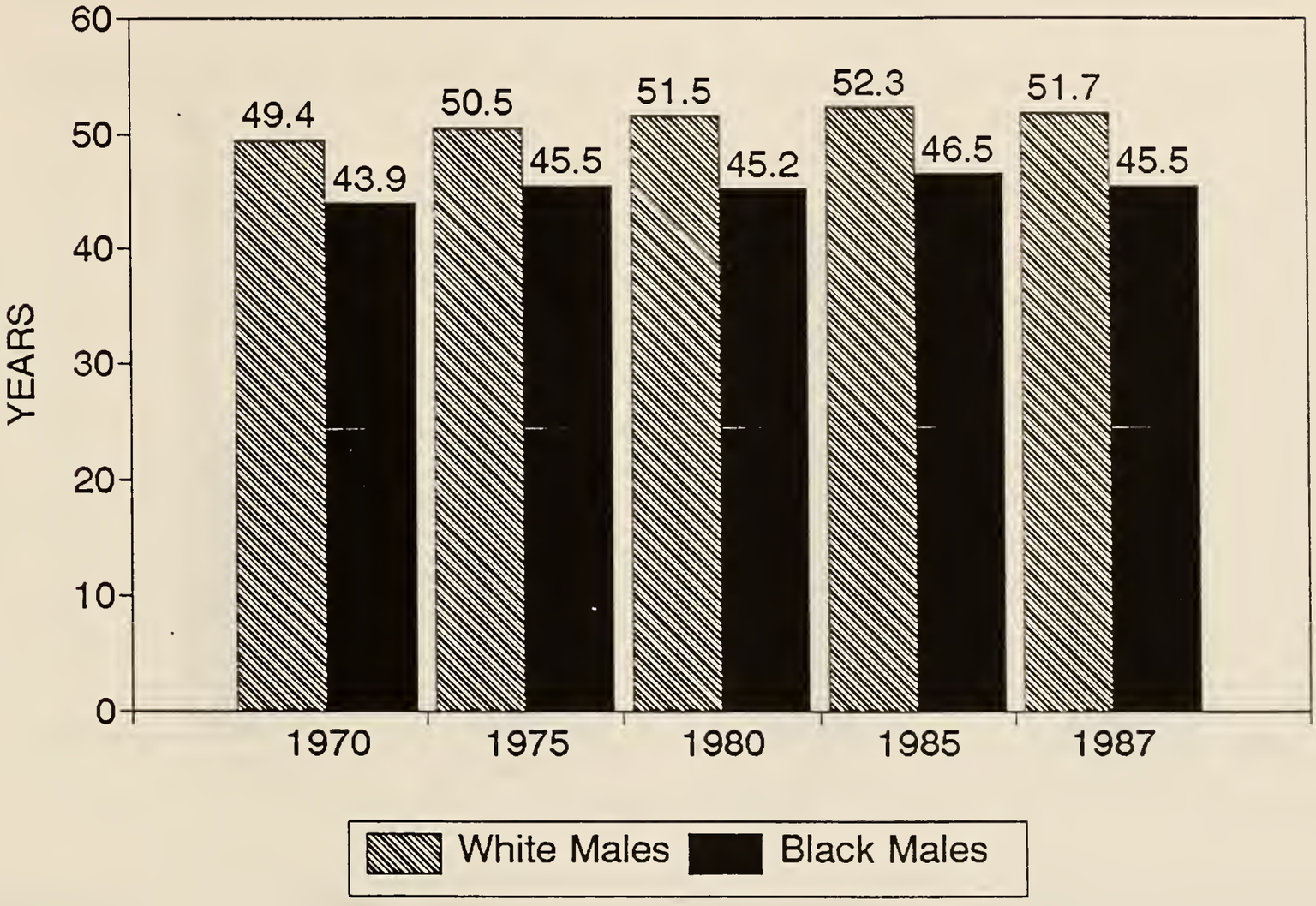
Life Expectancy at Birth for Males, by Race: United States, 1950-1987



Source: Figure prepared by Policy Research Incorporated, based on data from: National Center for Health Statistics. Health U.S. 1989. Hyattsville, Maryland: Public Health Service, 1990, p. 106

Figure 3.2.2

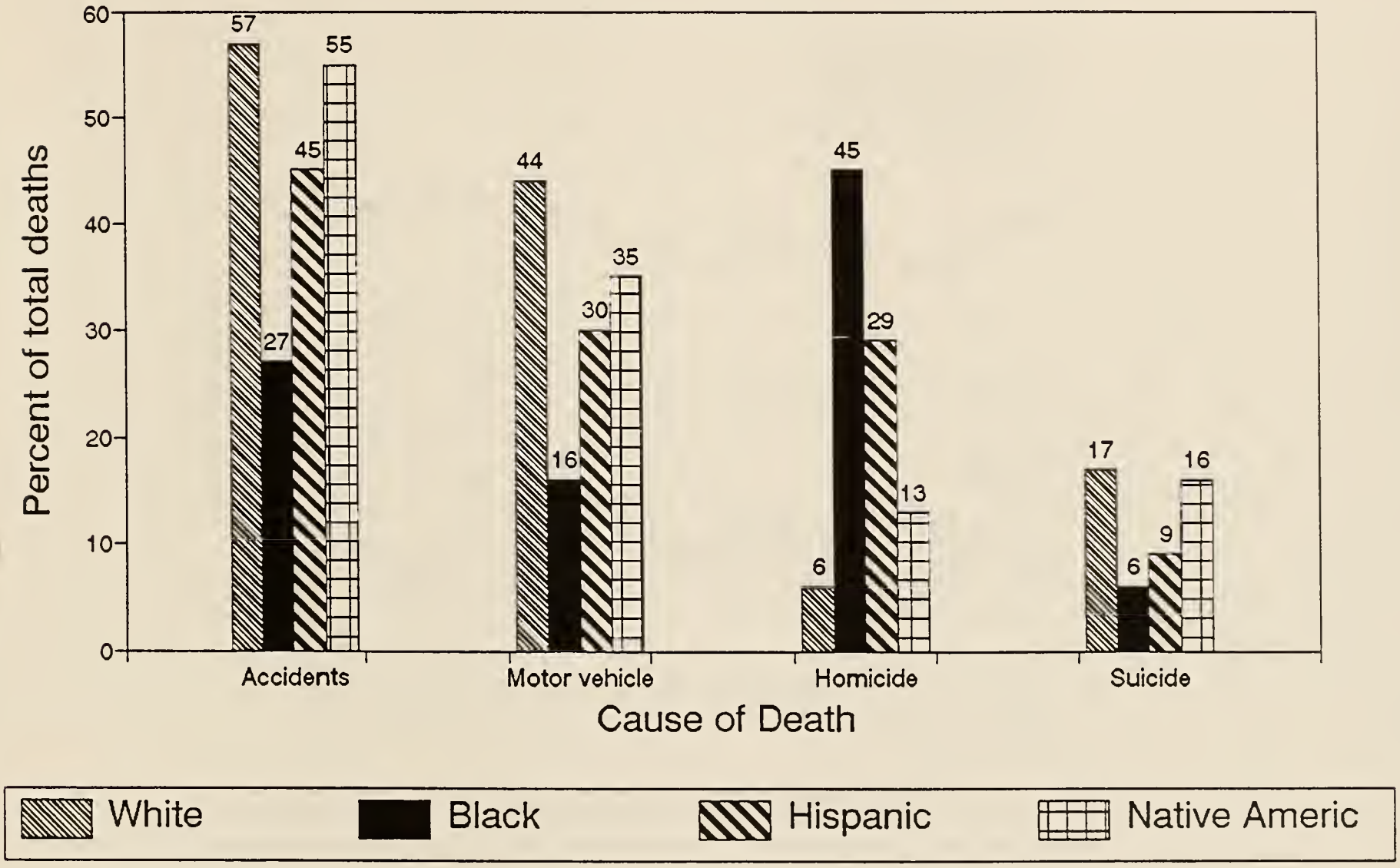
Life Expectancy at Age 21 for Males, by Race: United States, 1970-1987



Source: Figure prepared by Policy Research Incorporated, based on data from: National Center for Health Statistics, personal communication, Jun 1990

Figure 3.2.3

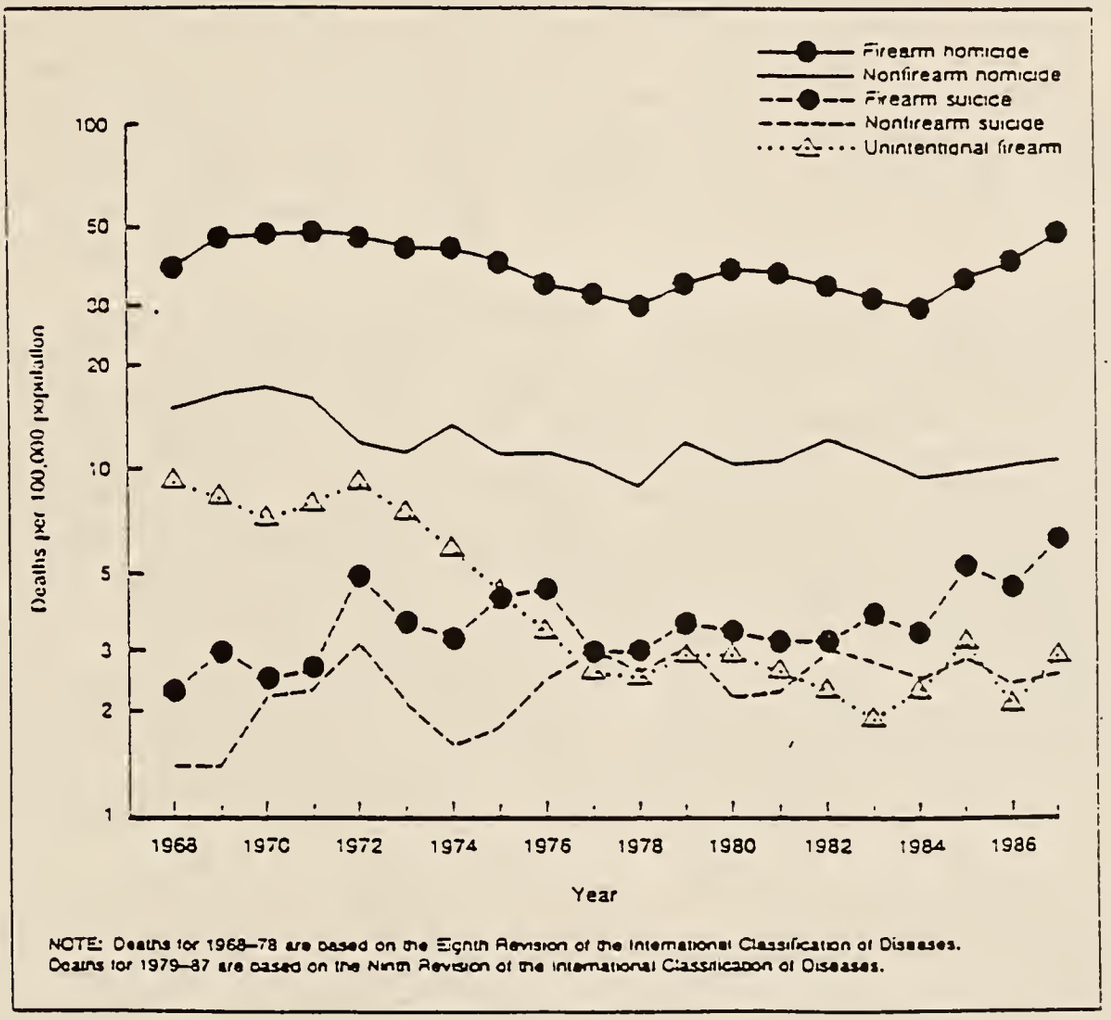
Percent Distribution of Death for Adolescent Males Ages 15-24 Years, by Race and Ethnicity: United States, Total of 18 Reporting States and District of Columbia for White, Black and Hispanic males, 1986 and Reservation States for Native American males, 1984-1986.



Source: National Center for Health Statistics. Vital Statistics of the United States, 1986, Vol. II, Mortality, Part A. DHHS Pub. No. 87-1122. PHS. Washington, DC: U.S. Government Printing Office; 1989 and Indian Health Service, Chart Series 1989, Public Health Service.

Figure 3.2.4

Firearm- and Nonfirearm- Related Death Rates for Homicide, Suicide, and Unintentional Injury, Black Males 15-19 Years of Age: United States, 1968-87



Source: Fingerhut LA, Kleinman JC. Firearm Mortality Among Children and Youth. NCHS. Advance Data for Vital and Health Statistics. No. 178; Nov 3, 1989, Fig. 6

3.3 PREVENTIVE HEALTH

3.3.1 Overview

For more than a decade, much interest had been focused on prevention as a means of improving the health status of Americans. The two key strategies of the Public Health Service have been: increased attention to preventive medical services and educational campaigns to reduce mortality caused by "lifestyle choices." In 1980, the Public Health Service published a set of national health objectives to be achieved by 1990.[1] An interim review of these objectives noted significant improvements in such areas as smoking reduction and reduced mortality from heart disease. However, the Review also suggested that success in achieving these goals specific to adolescents and young adults differed by economic status, race and ethnicity.[2]

In this section, preventive health as it pertains to male adolescents is addressed, with discussion centering on the indicators appropriate for this population. Adolescents are less likely than adults to require preventive services such as cancer screening procedures or blood pressure tests; likewise, unless they have missed the immunizations required at an earlier age, adolescents no longer require immunizations for childhood diseases. Since this report deals with adolescent males, prenatal care and practices, a crucial area in preventive health services, is not relevant. What this section discusses are the personal health-related habits of adolescent minority males, including smoking, nutritional status, and sexually transmitted diseases (with a separate section on HIV infection). Self-assessments of adolescent health are also presented. Finally, dental health and use of dental services by adolescents are discussed.

Differences in health status between minority and White adolescents underscore the importance of providing health education geared specifically to minority adolescents. In examining the leading causes of death and disability among this population, preventable risk factors are easy to identify. For example, in the areas of homicide, suicide, and unintentional injuries -- the leading causes of death among adolescent males -- alcohol or other drug abuse, stress, and handgun availability are prominent risk factors.[3] Because behavioral and environmental risk factors are associated with the causes of excess deaths among minority adolescent males, the Secretary's Task Force on Black and Minority Health suggests that "more work needs to be done in the area of health education" and especially in the areas of "misuse of alcohol and drugs, use of tobacco, dietary habits, and management of stress."[4]

3.3.2 Self-assessments of Health

Self-assessed health, generally accepted as a reasonably valid measure of health status, may have implications for the propensity to practice preventive health behaviors. Most Americans in the noninstitutionalized population assess their health as very good or excellent;[5] relatively few adolescents and young adults consider themselves in poor health. However, surveys of self-assessed health status indicate that the responses vary by race and income; Black Americans and lower-income Americans are more likely to consider themselves in poorer health.

Table 3.3.1 presents data from the 1982 and 1987 National Health Interview Survey concerning self-perceptions of health status for children and adolescents ages 5 to 17 and young adults ages 18 to 24. According to the National Center for Health Statistics, in administering the Household Interview Survey, proxy respondents are used for persons under age 19,[6] although persons 17 and 18 years of age may respond for themselves. Health assessments for children and adolescents ages 5 to 17 are, therefore, in almost all cases, made by a parent or adult guardian.

In both age groups, racial differences are evident. Whites ages 5 to 17 were almost one and a half times as likely in 1982 and 1987 to assess their health as excellent compared to Black adolescents in the same age group. More specifically, in 1987 56.1% of all White respondents age 5 to 17 assessed their health as excellent compared to only 39.7% of all same-age Black Americans. The racial difference in assessment of excellent health among those ages 5 to 17 was substantially greater than for any other age group for both years.[7] [8] In fact, the Black/White difference in self-assessed excellent health among children and adolescents was more than twice as great as the difference for all ages. Conversely, Black youth ages 5 to 17 were more than twice as likely to assess their health as fair compared to Whites (see Table 3.3.1). These differences are noteworthy because they have remained relatively constant over a five year period between 1982 and 1987. Secondly, health indicators demonstrate that adolescence is one of the healthiest periods in a person's life. Among young adults age 18 to 24 in 1987, White youth were 25% more likely to consider themselves in excellent health compared to Black youth, and about half as likely to assess their health as fair or poor (see Figure 3.3.1). This difference has narrowed since 1982 when White youth were 41% more likely to consider themselves in excellent health compared to Black youth.

Table and Figure 3.3.2 indicates that although Black adolescent males ages 12 to 17 were more than twice as likely to report themselves in fair or poor health compared to their White counterparts, Black adolescent males were less likely to report spending seven or more days in bed due to illness or injury during the last year. Moreover, young Black males were less likely than

all other race and sex groups in Table 3.3.2 to report spending seven or more days in bed due to illness during the last year.

3.3.3 Tobacco Use

Smoking is a cause of numerous health problems, including coronary heart disease, cancers of various sites, and cerebrovascular and peripheral vascular disease. In 1986, approximately 390,000 Americans died as the result of past and current smoking. This represents more than one of every six deaths in the United States.[9]

Several factors have prompted increased concern in youth smoking prevention efforts, including evidence suggesting that the earlier the age of onset, the greater the smoking involvement later on.[10] [11] Another factor is the disappointing results of adult smoking cessation programs.[12] The prevention of smoking among youth has been given high priority by the Centers for Disease Control's Center for Health Promotion and Education, since the vast majority of smokers begin when they are teenagers.[13] Only 10% to 15% of current smokers begin smoking after age 19.[14] According to Dr. Louis W. Sullivan, Secretary of Health and Human Services,

> "Smoking is the single most preventable cause of death in the United States. The really disheartening news is that some one million teens start smoking each year; this amounts to about 3,000 each day, and many of these go on to become addicted for life. In fact, about 90 percent of adult smokers began their addiction as children or adolescents, so the conclusion is clear: these young smokers account for almost all of our future problems."[15]

From existing studies, including the NIDA surveys and regional analyses to be discussed, a more detailed picture of racial/ethnic differences in smoking among adolescents emerges. Assuming smoking initiation patterns are similar across racial/ethnic groups, an excess of smoking among minority adolescents and young adults, particularly the more disadvantaged ones (i.e., youth of low educational attainment), is reflected by data available on adult minority smoking. With respect to Hispanics, there is increasing evidence that smoking onset may be increasing, especially among Mexican-Americans.[16] [17]

Sussman et al.[18] identified ethnic differences in self-reported rates of smoking initiation in 1982-83 among Southern California White, Black, Hispanic and Asian adolescents as they moved from seventh to eighth grade. The prevalence of those ever trying a cigarette (i.e., the percentage of seventh graders and eighth graders who had ever tried a cigarette) and the smoking onset rates (i.e., the percentage of seventh grade nonsmokers who had tried a cigarette by the eighth grade) were highest among Hispanic and Black adolescents, followed by White adolescents; they

were lowest for Asian adolescents. Notably, the ethnic composition of the schools did not appear to affect ethnic patterns in smoking initiation.[19]

The results in the Sussman et al. study are consistent with other reported ethnic differences in smoking onset rates in California.[20] The authors note, however, that other reports indicate a higher percentage of regular smoking (i.e., smoking cigarettes on a monthly or weekly basis) among White young adults than among Hispanic or Black young adults, suggesting differential quitting patterns by ethnic groups or regional differences in onset. An earlier study in 1979[21] of inner-city Black youth in Harlem found that 57% were smokers, a higher percentage than the 29% reported for all high school seniors in 1988. Finally, the Hispanic Health and Nutrition Examination Survey (HHANES), conducted in 1982-83, indicated that smoking initiation among Puerto Rican males ages 20 to 24 had not declined during the mid-70s and early 1980s compared to Mexican American, Cuban American, and White American males of the same age.[22] Escobedo et al.,[23] in analyzing the HHANES data, indicate lower educational attainment, low social standing, and poor access to health care information for Hispanics in New York City (where many Puerto Rican adolescents live) as contributing factors.

Although some studies have found that smoking among Asian American adolescents is rare,[24] an examination of smoking among the immigrant and refugee Asian populations indicates a high prevalence. All Asian immigrant groups reflect a higher prevalence of smoking than their U.S. born Asian counterparts, and certain groups such as Korean immigrants and Vietnamese refugees exceed all others in terms of smoking prevalence.[25] In a study conducted in San Diego for example, 65% of all Vietnamese males reported that they smoke regularly.[26] Another study noted that smoking among Asian and Pacific Islanders is clearly a risk factor associated with males and age.[27]

Examining the smoking behavior of high school students is instructive, because the relationship between smoking and the expectation regarding further education can be readily examined. Thus, behavior differences attributable to factors other than educational attainment are easier to analyze. According to a survey of high school seniors and young adults conducted by the National Institute on Drug Abuse in 1987, smoking one or more cigarettes daily for the past 30 days was more than twice as frequent among the non-college bound students (29.0%) as among the college bound (13.3%).[28] In addition, nearly one in five (19.5%) of the non-college bound students smoked one-half pack or more, compared to about one in 14 (7.2%) among the college bound. These differentials were similar to those found in NIDA's 1986 survey of high school students. These surveys, which have received much national publicity, are not disaggregated by race or ethnicity. However, they appear consistent with studies of adult smoking which

have concluded that educational attainment is the most important variable explaining smoking variations.[29]

Smokeless tobacco in the form of chewing tobacco and snuff is a highly addictive substance that poses many health problems for the growing number of children and adolescents who use it.[30] There is particular concern regarding the widespread use of smokeless tobacco among Native American adolescents. According to a recent study,[31] although the use of smokeless tobacco products varies by ethnic status, sex, and to a lesser extent, grade level, Native American use in all these areas was higher than non-Native American use. A survey of 1,180 6th, 9th and 11th graders in the State of Washington found that 34% of male Native Americans compared to 20% of male non-Native Americans were current users of smokeless tobacco products. Oral leukoplakia, a white thickening of the oral mucosa, is a common consequence of smokeless tobacco use and is considered to be a dangerous precancerous condition.

Recent studies indicate that minority groups may be at relatively high risk for lung cancer and other smoking-related diseases.[32] Lately, an additional cause for concern is new policies of cigarette manufacturers who specifically target and promote their product in minority neighborhoods.[33] [34] According to Davis[35] who has documented this marketing, the targeting of minority populations has occurred in several ways; for example:

1) Certain cigarette brands have been specifically promoted among the Black community (for instance, Kool, Winston, More, and Salem brands)[36] and among the Hispanic community (for instance, Rio, Dorado, and L&M Superior brands).[37] In one study, Newport, Salem, and Kool accounted for 60% of all cigarettes purchased by Black Americans, indicating the success of this marketing technique.[38]

2) Cigarettes are heavily advertised in Black-oriented publications such as Ebony, Jet and Essence and Philip Morris has published a directory of national Hispanic organizations, which has numerous cigarette advertisements in English and Spanish.[39]

3) Another type of advertising aimed at minority communities is the use of billboard campaigns. In 1985, 37% of all cigarette advertising using this medium was aimed at Black communities, making cigarette companies the leading advertisers. In the same year, cigarette companies were also the heaviest advertisers on billboards in Hispanic communities -- twice as much money was spent on cigarette advertising compared to the next most heavily advertised product, liquor.[40]

A third cigarette advertising policy with adverse effects for young minority males is the targeting of certain groups in which

they are overrepresented, such as military recruits[41] and prisoners[42]. Both of these populations have among the highest smoking rates reported for any groups.[43] [44] Finally, Davis points out that other promotional methods used to target minority populations include sponsorship of athletic, civic, cultural and entertainment events by cigarette companies, which in many cases include free samples.

In light of these advertising campaigns, Secretary of Health and Human Services, Dr. Louis W. Sullivan, has increasingly focused attention on the problem of smoking, aiming his efforts at disadvantaged minority populations. For instance, Dr. Sullivan publicly called on R.J. Reynolds Tobacco Co. to withdraw its plans to test-market a new cigarette brand aimed at Black Americans.[45] Citing the disparity in health status between Black and White Americans, Secretary Sullivan described himself as "alarmed and angered"[46] by the Reynolds Co. plan. In addition, Secretary Sullivan indicated that this should be "the beginning of all-out effort, for there are other companies who are doing the very same thing."[47] To prevent the sale of cigarettes to minors, Secretary Sullivan has proposed model state legislation which would ban cigarette vending machines and provide for a licensing system similar to that used to control the sale of alcoholic beverages.[48] These proposals were created as a result of a study, Youth Access to Cigarettes,[49] commissioned by the HHS Secretary. The study determined that despite the existence of laws in 44 states and the District of Columbia prohibiting the sale of cigarettes to minors, these laws are not enforced.

3.3.4 Nutritional Patterns

Evidence from several nutritional studies indicate that shortcomings in diet and nutrition, with consequent detrimental effects on health status, affect some disadvantaged groups disproportionately.[50] [51] Factors which may contribute to health disparities in nutritional status between minority adolescents and White adolescents include 1) income (a higher proportion of minority populations have low-incomes); 2) obesity (high prevalence of obesity in some minority populations); and 3) traditional diets (e.g., high fat content).[52] Unfortunately, literature on the topic of adolescent nutrition is limited.

Most recent studies of nutritional status of disadvantaged children and adolescents have been conducted among low-income youth and cannot be generalized to all Black and minority youth. Existing analyses of data from the second National Health and Nutrition Examination Survey (NHANES II, 1976-80) have not revealed a clear picture of the nutritional risk among minority youth. A new national health and nutrition survey, NHANES III, is currently being conducted and may add further information on the nutritional status of minority adolescents, but results from NHANES III will not be available until 1995-1996.

A study published in 1971 found that one-third of all children in a sample of 9,000 socioeconomically disadvantaged children in Baltimore revealed signs of malnutrition such as deficiencies in Vitamin A, carotene, total protein and serum albumin.[53] This study indicated that the rapid growth exhibited during adolescence exacerbated the poor nutritional status of disadvantaged youth. NHANES II data show that, although no major nutritional deficiencies among Black adolescents were detected, a preference for salty food and a habit of meal skipping may be problematic.[54]

As with Black adolescents, findings have not indicated a clear pattern of nutritional deficiency among Hispanic youth. Alvarez et al.[55] reported that in 1978, 13% of all Hispanic children from an inner-city neighborhood health center were acutely undernourished. Other sources have reported low iron intakes, low blood iron status, or low nutritional intakes among Hispanic children or adolescents.[56] [57] These data are in contrast to 1971-1981 data from the Centers for Disease Control, which did not find such low values among Hispanic children,[58] and the National School Lunch Program,[59] which did not find any major differences between the 24-hour dietary intake of Hispanic children compared to White children.

Two consistent findings in studies of Hispanic children and adolescents are: a disproportionate risk of stunted growth and an excess prevalence of overweight.[60] The prevalence of high weight for height among Hispanic adolescents was significantly greater than among White adolescents.[61] [62] Although the problem of stunted growth is confined to populations of lower economic status and in particular to immigrant and migrant groups, the problem of obesity among adolescents is found across socioeconomic levels.[63] Mexican Americans are particularly vulnerable to obesity at all ages.

Documentation of excess prevalence of obesity among Native Americans of all ages is also widely reported.[64] Although no specific studies of adolescent Native Americans have been conducted, studies of preschool children among various tribes have shown a relatively high prevalence of obesity.[65] In addition, the excess rates of both stunted growth and obesity among low-income Native American children may indicate poor and inadequate diets.[66] Obesity among Native Americans has received considerable attention, in part because of the higher than average prevalence of adult onset diabetes among many Native American tribes.[67] Heavy alcohol use by Native American adolescents (see Section 3.5 of this report) also poses special nutritional risks in this population.

Data on the nutritional status of Asian American children and adolescents indicate that it is comparable to U.S. standards, as measured by weight-for-height and blood content indexes for the period 1979 to 1983.[68] Southeast Asian refugee adolescents, on the other hand, experience more serious health and nutrition problems.

A study examining Southeast Asian refugees who relocated to Connecticut suggests that nutritional abnormalities may be more prevalent among refugee children.[69] The study found that almost half of all children were below the height-for-weight index and one-fifth were below the weight-for-height index. These percentages are substantially higher than the rates found for Asian Americans overall.[70] Other studies found that Southeast Asian refugees, adults and adolescents, are carriers of -- or suffer from -- tuberculosis, hepatitis B, and malaria at much higher rates than the U.S. population generally.[71] One study indicated that up to 80% of Southeast Asian refugees have intestinal parasites.[72]

Another group at risk for nutrition-related problems consists of migrant workers. The Child Development Center at Georgetown University, Washington, DC, conducted a study in 1986 on nutrition and migrant health.[73] There are an estimated three to five million migrant and seasonal farm workers and dependents, and in 1985, 552,000 hired farm workers were aged 14 to 17 and 739,000 were aged 18 to 24.[74] According to the Georgetown study,[75] the major nutrition-related problems of migrant adolescents ages 13 to 19 were dental health and "poor housing and cooking facilities." Overweight and infections were identified as the next most significant problems, followed by anemia. Poor Americans tend to consume food with higher starch and fat content; independent studies have demonstrated that many migrant children are malnourished.[76] This undernutrition among migrant adolescents makes them especially vulnerable to such infectious diseases as dysentery, hepatitis B, typhoid fever, and other intestinal and respiratory ailments.[77]

3.3.5 Dental Health

The most recent data available to assess racial differences in children's dental health comes from the survey of Oral Health of U.S. School Children, conducted by the National Institute for Dental Research (NIDR) during the 1986-1987 school year. The population for this survey consisted of all U.S. children and adolescents enrolled in kindergarten through grade 12 in public or private schools.[78] The prevalence of tooth decay (whether treated or not) has been declining in U.S. school children since the 1970s.[79] However, between 1979-1980 and 1987, mean numbers of decayed, missing, and filled teeth decreased twice as fast for White children as for minority populations.

Results from NIDR's 1986-87 survey indicate that children and adolescents of racial minority groups (Black and all others) between the ages of 5 and 17 have slightly higher average numbers of decayed, missing, and filled tooth (DMF) surfaces than do White children of the same age.[80] This indicates a deterioration in dental care for minority adolescents since 1979-80, when minority children had better average scores. An indicator of treatment status, the proportion of DMF surfaces filled, suggested that

greater treatment need exists among minority children. The percentage of DMF surfaces filled for White children was 87.5%, compared to 67.0% for non-White children.

In contrast to the small excess in caries found among minority adolescents, data from the Indian Health Service's Oral Health Survey raise the possibility that Native American children and adolescents have a dental health status that is substantially poorer than that of other Americans of the same age.[81] However, the Indian Health Service (IHS) survey, conducted in 1983-1984, has considerable limitations.[82]

The NIDR survey has not yet produced reports on tooth decay among Hispanic American children; however, data are available from the Southwestern Hispanic Health and Nutrition Examination Survey (HHANES). Carried out among Hispanic Americans in five southwestern states in 1982-1983, the survey results are considered applicable to 84% of the Mexican American population in the United States.[83] Southwestern HHANES indicates that, among all surveyed Mexican American children and adolescents 5 to 17 years of age, mean dental scores for Mexican American children in 1982-1983 did not differ significantly from mean dental scores of children from the same region surveyed in the National Caries Prevalence Survey in 1979-1980.[84] (In general, adolescents have fewer cavities in the Southwest than in other parts of the country, because of natural fluoride in community water supplies.[85])

While periodontal disease is most prevalent in those over 35, it is also of concern for children, especially in its incipient forms. A subsample of children age 14 to 17 from the 1986-87 NIDR school children survey received periodontal exams.[86] Black adolescents had a one-third higher prevalence of gingival bleeding than did White adolescents. Hispanic adolescents had a prevalence of gingival bleeding similar to White children. Results of a 1984-1985 study of 618 Native American (mostly Navajo) adolescents ages 14 to 19 residing in a New Mexico boarding school also suggest high prevalence of periodontal conditions; 70.6% had gingival bleeding.

Low income, Black, and Mexican American adolescents were much more likely than their general-population counterparts not to have seen a dentist within a year or to have never seen a dentist at all.[87] For all income groups and races, adolescents with health insurance visit dentists more often than those without insurance.[88] Minority adolescents are less likely to be insured than White ones (see discussion in Section 4). But regardless of insurance status, Black adolescents and schoolchildren age 5 to 17 still appear to make fewer visits than their White counterparts.[89]

The data suggest that minority children and adolescents have higher levels of tooth decay compared to White children. Native American youth have particularly high levels of tooth decay compared to all U.S. youth. With respect to periodontal disease,

this section indicates that Black children have more periodontal disease compared with White children. The data also suggest greater dental needs among racial and ethnic minority children and adolescents. Finally, access to dental care appears to be limited among disadvantaged adolescents compared to the rest of the population.

3.3.6 Sexuality and Sexually Transmitted Diseases

In one of the first studies of family planning services for teenagers, conducted in 1974, it was found that, while male attendance was observed in over half of the 40 clinics in the sample, there were few activities (e.g., education, counseling) directed toward males.[90] Moreover, present interventions aimed at teenage sexual behavior appear to be largely ineffective.[91] According to a review of published studies of sex education by Stout and Revere, "The available evidence indicates that traditional sex education programs in junior and senior high schools have little or no effect either positively or negatively on altering the age of onset or frequency of adolescent sexual activity, on increasing contraceptive use, or on preventing unplanned teenage pregnancy."[92]

Available data do not generally disaggregate statistics on male and female teenage sexual behavior, although intercourse rates are considerably lower for females than for males, irrespective of race.[93] There are dramatic differences in premarital sex and use of contraception among Black and White teenagers. Zelnick et al. in 1981 found that Black teenagers overall are significantly more likely to have premarital intercourse compared to White teenagers (Table and Figure 3.3.3). Nearly 40% of all Black teenagers reported having intercourse by age 15 compared to only 15% of all White teenagers. Overall, Black teenagers ages 15 to 19 were twice as likely, 62% vs. 32%, to have had premarital intercourse. In terms of age of initiation of sexual activity, several studies have indicated a large racial difference, one that is even greater for teen males than teen females.[94] Clark et al.[95] have shown that a substantial portion of Black males engage in sex prior to puberty.

Although more often sexually experienced than their White counterparts, Black teenagers are less likely to use contraception (Figure 3.3.4). Contraceptive use in Zelnick's study was loosely defined as reported use of contraception during last intercourse. For all teenagers surveyed, except 16-year olds, Black youth were less likely to have reported using contraception at last intercourse. Only about half of all 15-year old Whites reported using contraception at last intercourse, but the percentage for 15-year old Black youth is even smaller -- slightly more than one third had used any contraception. Unfortunately, there have been no recent studies on contraception use among adolescents since the emergence of the HIV infection and efforts to make the public aware

of the risks involved in unprotected intercourse.

The role and responsibility of the male in contraception use is very important. While the majority of adolescent males are infrequent contraceptive users, some studies suggest that this is particularly true for Black adolescents.[96] Clarke, Zabin and Hardy revealed that 89% of Black males and 69% of White males in a high school survey reported that they engaged in unprotected intercourse at least once.[97] Findings from the 1982 National Survey of Family Growth concerning contraceptive use among women ages 15 to 19 at risk for unintended pregnancy show that 30% of White and 35% of Black youth were using no preventive method.[98] Among Baltimore males attending inner-city junior or senior high school in 1981, nearly 40% of the sexually active respondents did not use birth control at last coitus.[99]

Increasing incidence of venereal disease has followed the upward trend in sexual activity and the limited use of contraceptives among adolescents. A frequently cited estimate is that sexually transmitted diseases (STDs) affect one in seven adolescents.[100] Table 3.3.4 shows that rates of primary and secondary syphilis and gonorrhea among teenage male adolescents differ dramatically by race and ethnicity. According to data from the Centers for Disease Control (CDC), the rates of syphilis among minority teenage males ages 15 to 19 between 1986 and 1988 were 30 to 50 times higher than rates of their White counterparts. In 1988, the most recent year for which data are available, the syphilis rate for Black and Hispanic male teens was 81.5/100,000 and 30.8/100,000, respectively, compared to 1.4/100,000 among White male teens. According to CDC officials,[101] a large portion of this discrepancy can be explained by the way in which STDs are reported; for example, publicly financed medical facilities are more likely to test for and report on positive STD results compared to private practitioners.[102] [103] Because minority adolescents are more likely than White adolescents to use public facilities, their STD results are more likely to be reported. A second caveat that must be considered when evaluating these STD rates concerns the potential for underestimating rates among the Hispanic population. In most cases, the race or ethnicity of the patient is identified by sight, and thus there is the possibility that persons of Hispanic origin may be classified as White or Black.[104]

Rates of gonorrhea among Black males ages 15 to 19 are also reported to be particularly high when compared to their White and Hispanic counterparts (see Table 3.3.4). In 1988, the gonorrhea rate among Black teen males was 5597.1/100,000 compared with 452.3/100,000 and 155.7/100,000 among Hispanic and White teen males, respectively (see Figure 3.3.5). Even more disturbing is the fact that between 1986 and 1988, Black males ages 15 to 19 were the only group of young males to show increases in both syphilis and gonorrhea rates (see Table 3.3.4) The rate for syphilis among Black male teens increased by 29% during this time. Preliminary

data for 1989 indicate that syphilis rates continued to increase at dramatic rates among young Black males, and they are projected to increase an additional 27% between 1988 and 1989.[105] Hispanic and White males in the same age group, however, showed steady and substantial decreases in both syphilis and gonorrhea rates between 1986 and 1988. The years between 1986 and 1988 are particularly important since, during this period, the first widespread efforts to alert adolescents to the risk of HIV were initiated.

Although there are no data on STDs for male adolescent Native Americans, a recent study concluded that the average rates of gonorrhea and primary and secondary (P & S) syphilis among Native Americans were more than double those found among non-Native Americans for 13 states examined from 1984 through 1988.[106] In some states, Native American rates were higher than those of any other minority group particularly for P & S syphilis in Arizona and New Mexico. Other studies that have examined STDs among Native Americans have also documented a disproportionate impact of STDs on Native American communities.[107] The Division of Sexually Transmitted Diseases at the Centers for Disease Control has expressed interest in conducting future studies on STD incidence among Native American adolescents.[108]

Data from regional studies provide the only estimates available on the incidence of STDs among Asian American males in comparison to other racial and ethnic groups. Surveillance of sexually transmitted diseases among males ages 15 to 19 in San Francisco between 1984 and 1988 indicated the following ranking of ethnic and racial groups with respect to gonorrhea cases per 100,000: Black (8708), Hispanic (1349), Asian (118), and White (58).[109] Among the same population, Asian males and White males reported no cases of early syphilis, while Black and Hispanic males reported 198/100,000 and 104/100,000 annual cases, respectively.

Unfortunately, rates for other STDs, e.g., herpes, chlamydia, and pelvic inflammatory disease (PID), are not reported to the CDC and thus, national data on adolescent rates are not available. Additionally, population-based surveys of the U.S. have not yet provided comprehensive information on adolescent (or adult) STDs partly because of the sensitive nature of this topic.

According to Gibbs, early initiation of sexual activity and negative attitudes towards condom use among Black males[110] are primary reasons for higher rates of STDs among that population. Another route of infection for STDs among the adolescent population is the pattern of adolescent females having older male partners.[111] Intravenous drug use, most commonly found among inner-city minority residents, has been associated with increased risk for sexually transmitted diseases. For example, Brunswick has noted that a high percentage of heroin users have gonorrhea.[112] Intravenous drug users are also at great risk of infection from the HIV virus (see below).

3.3.7 Human Immunodeficiency Virus Infection (HIV)

From 1981 until January 1990, 479 cases of Acquired Immunodeficiency Syndrome (AIDS) among adolescents 13 to 19 were diagnosed.[113] Seventy percent (380) of these cases were among males (see Table 3.3.5). Since the average latency period for the virus is approximately eight years, many adolescents contract the virus in their teens but do not become symptomatic until they are in their 20s. The racial breakdown of the adolescent cases among males -- 29% Black and 18% Hispanic -- displays an overrepresentation of minority populations, which is also found in the adult heterosexual and drug-using AIDS risk groups. Six Asian/Pacific Islanders and four Native American adolescents had been diagnosed with AIDS by January 1990.

In 1987, the death rate from the HIV infection among Black males ages 15 to 24 was three times higher than that of their White counterparts (see Section 3.2). The disproportionate representation of minority male adolescents in reported AIDS death cases is consistent with the higher prevalence of HIV infection among the inner city population (Figures 3.3.7 and 3.3.7).[114]

The prevalence of STDs among adolescents is one strong indicator of unsafe sex practices (e.g., non-monogamous sex or intercourse without use of condoms) and thus an indicator for HIV seroprevalence. Comparison of HIV with syphilis, for instance, must be tempered by the fact that syphilis appears to be more readily transmitted, at least in vaginal intercourse, than HIV.[115] Despite this caveat, HIV seroprevalence is expected to be much higher among minority adolescent males based on the data presented above.

National prevalence data for HIV infection are not available; however, smaller studies focusing on very specific populations have been conducted. These population-specific statistics indicate overrepresentation of the HIV virus among Black and Hispanic males. The prevalence of HIV infection in military recruits and Job Corps participants is one indication of the presence of the virus among adolescents and young adults. Between October 1985 and December 1986, the overall prevalence of seropositivity was four times as great in Black military recruits and almost three times as great in Hispanic recruits compared to White recruits.[116] Job Corps applicants, all of whom are economically disadvantaged youth between the ages of 16 to 21, are from predominately racial and ethnic minorities. Of the 84,089 residential Job Corps entrants tested since March 1987, 41/10,000 were positive for HIV antibody.[117] Unfortunately, Job Corps data are not disaggregated by race or ethnicity.

Although HIV prevention activities aimed at adolescent racial/ethnic minorities and intravenous drug abusers have

increased substantially in the past two years, there is little evidence of success of these programs.[118] For example, a study[119] of the knowledge, attitudes and misconceptions of students in San Francisco high schools, an epicenter of the epidemic, conducted in May 1985, indicated that White adolescents were more knowledgeable than Black adolescents about the cause, transmission, and prevention of AIDS. Black adolescents in turn were more knowledgeable than their Hispanic peers. Black and Hispanic adolescents were approximately twice as likely as White adolescents to have misconceptions about AIDS transmission.

Findings from the 1987-1988 National Adolescent Student Health Survey, which sampled students in the 8th and 10th grades, also indicate that minority adolescent males are less likely to be aware of the causes of HIV transmission and more likely to have misconceptions regarding the ways to reduce the risk of contracting the HIV virus compared with their White counterparts.[120] For example, 27% of White males and more than 40% of Black and Hispanic males said that they believed that the risk of AIDS could be reduced by washing after sex. Similarly, 26% of White males, 38% of Black males, and 45% of Hispanic males in this national sample reported that one is "less likely to get AIDS from a partner who looks healthy." Moreover, this survey also found that minority youth, especially males, are less aware than White youth of the behaviors that risk HIV transmission.[121]

Exacerbating the lack of information, minority adolescents tend to perceive themselves less at risk from HIV infection.[122] It is not clear whether minority adolescents are simply misinformed about AIDS or whether the risk of HIV infection is perceived to be more distant than other risks in their lives, such as homicide. This may be due to the fact that minority adolescents often view AIDS as exclusively a disease of White, homosexual men.[123]

Table 3.3.1

Number of Persons and Percent Distribution by Respondent Assessed Health Status by Race and Age: United States, 1982 and 1987

Characteristic	All Persons[1]	All Health Statuses[2]	Respondent Assessed Health Status				
			Excellent	Very Good	Good	Fair	Poor
	Number in Thousands		Percent Distribution				
1982							
White							
5-17 years	37,212	100.0	54.8	25.2	17.4	2.2	0.3
18-24 years	24,059	100.0	47.3	29.2	19.9	3.2	0.4
Black							
5-17 years	6,680	100.0	34.0	22.7	37.4	5.0	0.9
18-24 years	3,850	100.0	33.5	25.5	30.6	9.3	1.2
1987							
White							
5-17 years	36,613	100.0	56.1	27.0	14.7	1.8	0.3
18-24 years	21,390	100.0	45.0	31.8	19.7	3.1	0.4
Black							
5-17 years	6,978	100.0	39.7	25.6	30.5	3.7	0.5*
18-24 years	3,618	100.0	35.8	27.4	29.1	6.7	1.0*

*Relative standard error more than 30 percent.

[1]Includes unknown health status.
[2]Excludes unknown health status.

Source: National Center for Health Statistics, Current Estimates from the National Health Interview Survey: United States, 1982. Vital and Health Statistics Series 10, No. 150, DHHS Pub. No. (PHS) 85-1578. National Center for Health Statistics, Current Estimates from the National Health Interview Survey: United States, 1987. Vital and Health Statistics Series 10, No. 166, DHHS Pub. No. (PHS) 88-1594

Table 3.3.2

Health Status of Adolescents Ages 12-17 Years, United States: 1985-1986

	7 or More Beddays In Year	Limited In Activity	In Fair Or Poor Health
	Percent of Adolescents		
All Races	12.8	6.4	2.8
Male	10.2	7.3	2.5
Female	15.5	5.5	3.2
White	13.8	6.6	2.2
Male	11.0	7.6	2.0
Female	16.8	5.5	2.5
Black	8.7	6.3	6.0
Male	7.0	6.7	5.3
Female	10.4	5.9	6.6

Source: Wallace HM, Ryan G Jr., Oglesby AC. "Maternal and Child Health Practices," Third Edition, Third Party Publishing Company, 1988, Tbl 6, p. 528

Table 3.3.3

Sex and Contraception Among Teenagers Ages 15 to 19, by Race, United States: 1981*

	Black	White
Percentage of all teens having premarital intercourse		
15 years	38.5	15.2
16 years	53.0	24.0
17 years	69.3	39.3
18 years	76.8	50.3
19 years	84.2	56.6
Percentage of never-married teens having premarital intercourse	62.3	31.7
Percentage of never-married teens using contraception at last intercourse		
15 years	35.3	55.3
16 years	69.0	50.0
17 years	55.9	64.6
18 years	65.1	71.9
19 years	55.2	74.0
Percentage of premaritally sexually active teens who had a premarital pregnancy		
15 years	23.5	21.5
16 years	18.2	7.7
17 years	31.8	23.6
18 years	44.6	25.5
19 years	64.1	35.4
Percentage of premaritally pregnant teens with live births who married while pregnant	10.4	61.8

*Data gathered by Zelnik, Kanter and Ford (Johns Hopkins University) from nationwide surveys and published in 1981.

Source: Boone MS. "Capital Crime: Black Infant Mortality in America," Sage Publications, Inc. 1989, p. 102

Table 3.3.4

Primary and Secondary Syphilis; Reported Cases for Male Teenagers 15-19 Years of Age Per 100,000 Population by Race: United States, 1986-1988

Year	Total	Total Males	White Total	White Males	Black Total	Black Males	Hispanic Total	Hispanic Males	Other Total	Other Males
1986	2950	1420	312	126	2065	872	545	407	28	15
1987	3643	1523	326	108	2744	1043	547	359	26	13
1988	4005	1501	366	95	3169	1130	458	272	12	4

PRIMARY AND SECONDARY SYPHILIS

Age-Specific Case Rates Among Male Teenagers 15-19 Years of Age Per 100,000 Population by Race

United States 1986-1988

Year	Total	Total Males	White Total	White Males	Black Total	Black Males	Hispanic Total	Hispanic Males	Other Total	Other Males
1986	16.0	15.2	2.3	1.9	74.9	63.2	32.8	48.1	4.6	4.7
1987	19.9	16.4	2.5	1.6	99.3	75.4	32.3	41.7	4.0	3.9
1988	22.1	16.3	2.8	1.4	114.4	81.5	26.4	30.8	1.8	1.1

GONORRHEA

Reported Cases Among Male Teenagers 15-19 Years of Age by Race

United States 1986-1988

Year	Total	Total Males	White Total	White Males	Black Total	Black Males	Hispanic Total	Hispanic Males	Other Total	Other Males
1986	231073	96657	51915	15039	166264	74574	10813	6335	2081	709
1987	214085	93018	43929	12545	159316	74871	9016	4983	1817	619
1988	200340	92284	33902	10249	157743	77631	7393	3998	863	406

GONORRHEA

Age-Specific Case Rates for Male Teenagers 15-19 Years of Age Per 100,000 Population by Race

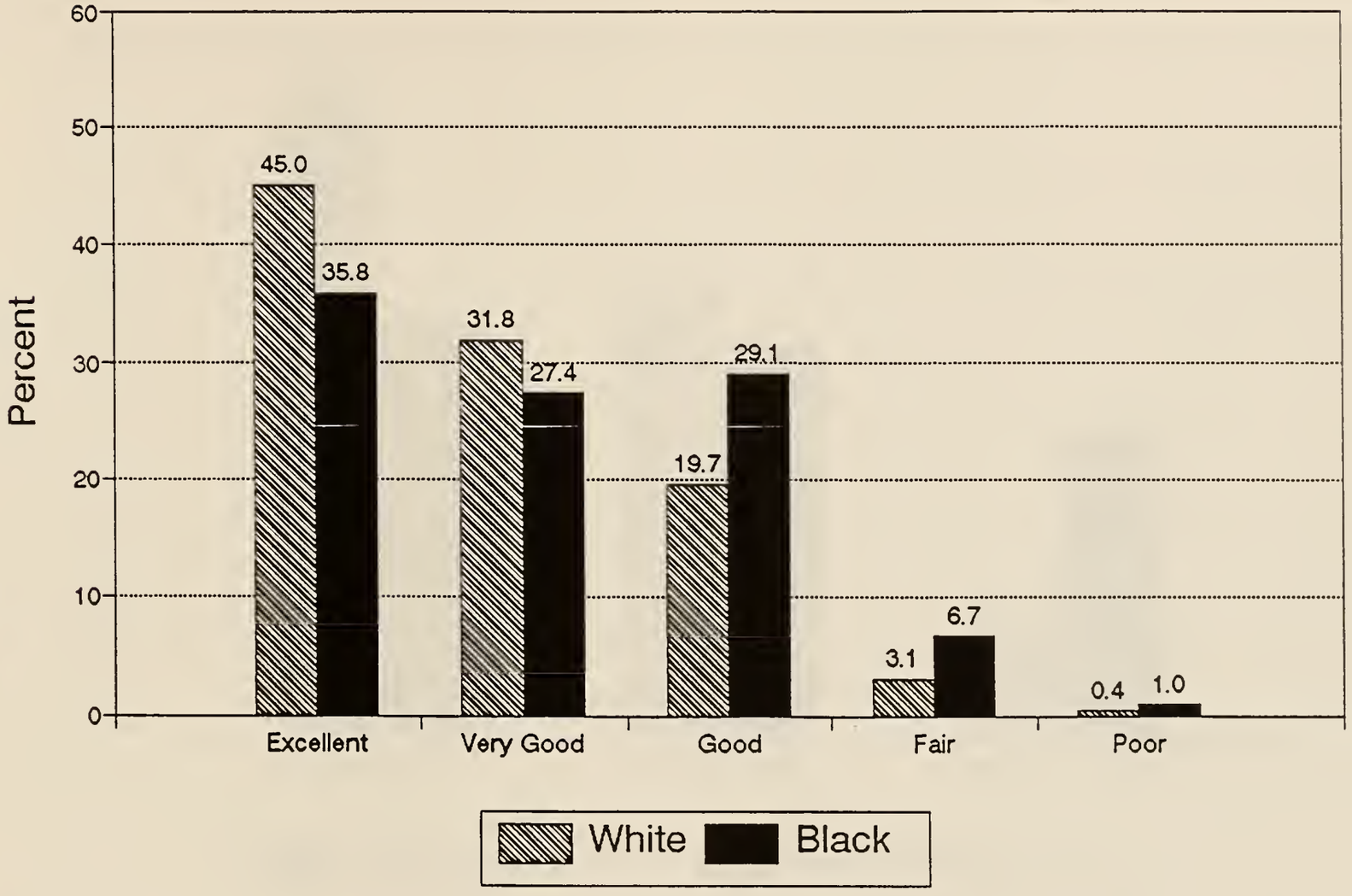
United States 1986-1988

Year	Total	Total Males	White Total	White Males	Black Total	Black Males	Hispanic Total	Hispanic Males	Other Total	Other Males
1986	1252.0	1034.5	386.8	221.2	6028.4	5407.8	650.5	748.8	338.9	223.0
1987	1169.3	1002.9	332.6	187.4	5764.0	5413.7	533.1	578.6	280.4	184.2
1988	1103.0	1002.3	261.2	155.7	5694.7	5597.1	426.6	452.3	126.1	114.3

Source: Centers for Disease Control, Division of Sexually Transmitted Diseases/HIV Prevention. Data sent to Policy Research Incorporated from Bill Jenkins, CDC, May 1990.

Figure 3.3.1

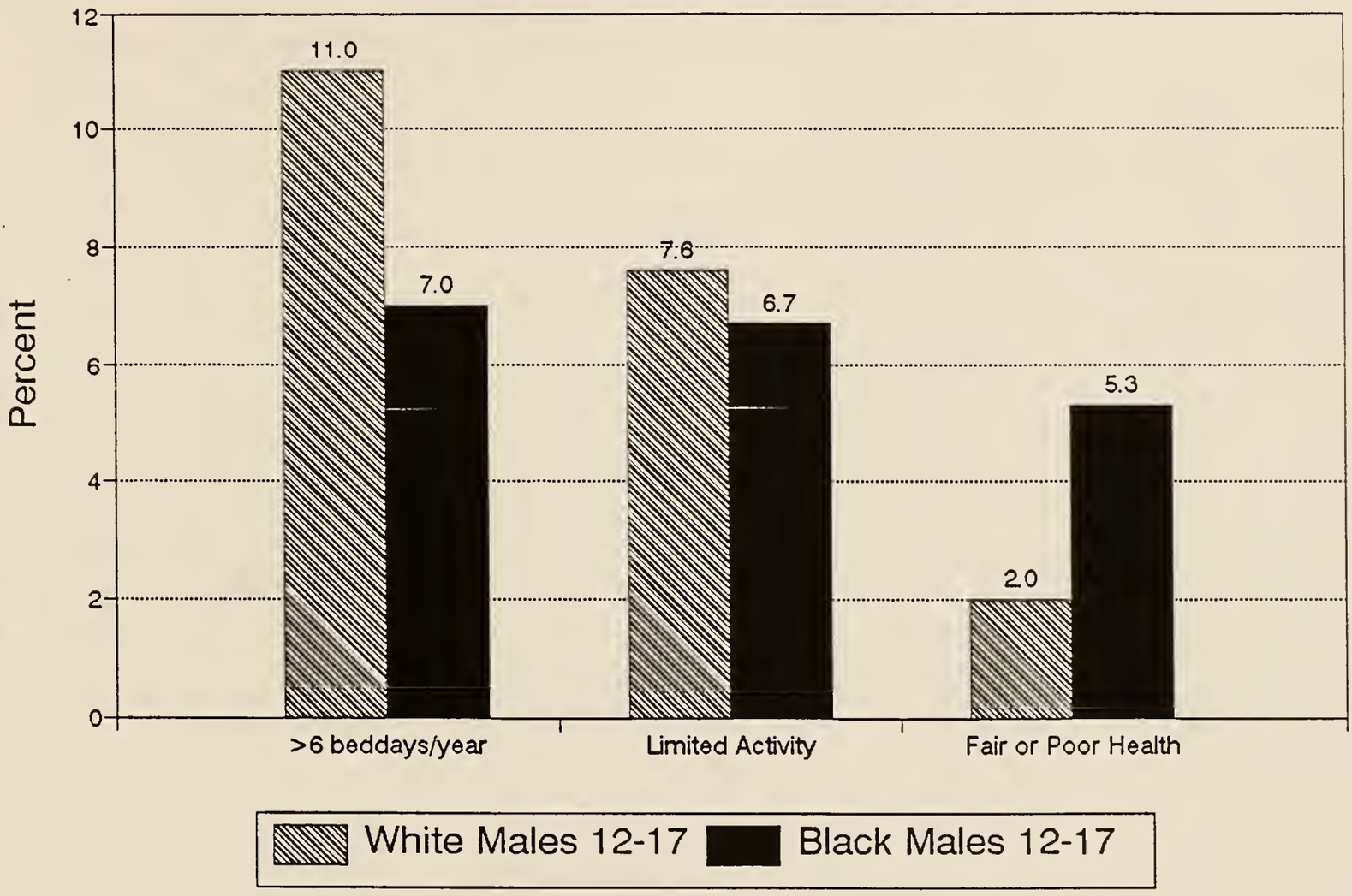
Percent Distribution by Respondent Assessed Health Status for Young Adults ages 18 to 24, by Race: United States, 1987



Source: National Center for Health Statistics, Current Estimates from the National Health Interview Survey: United States, 1987. Vital and Health Statistics Series 10, No. 166, DHHS Pub. No. (PHS) 88-1594

Figure 3.3.2

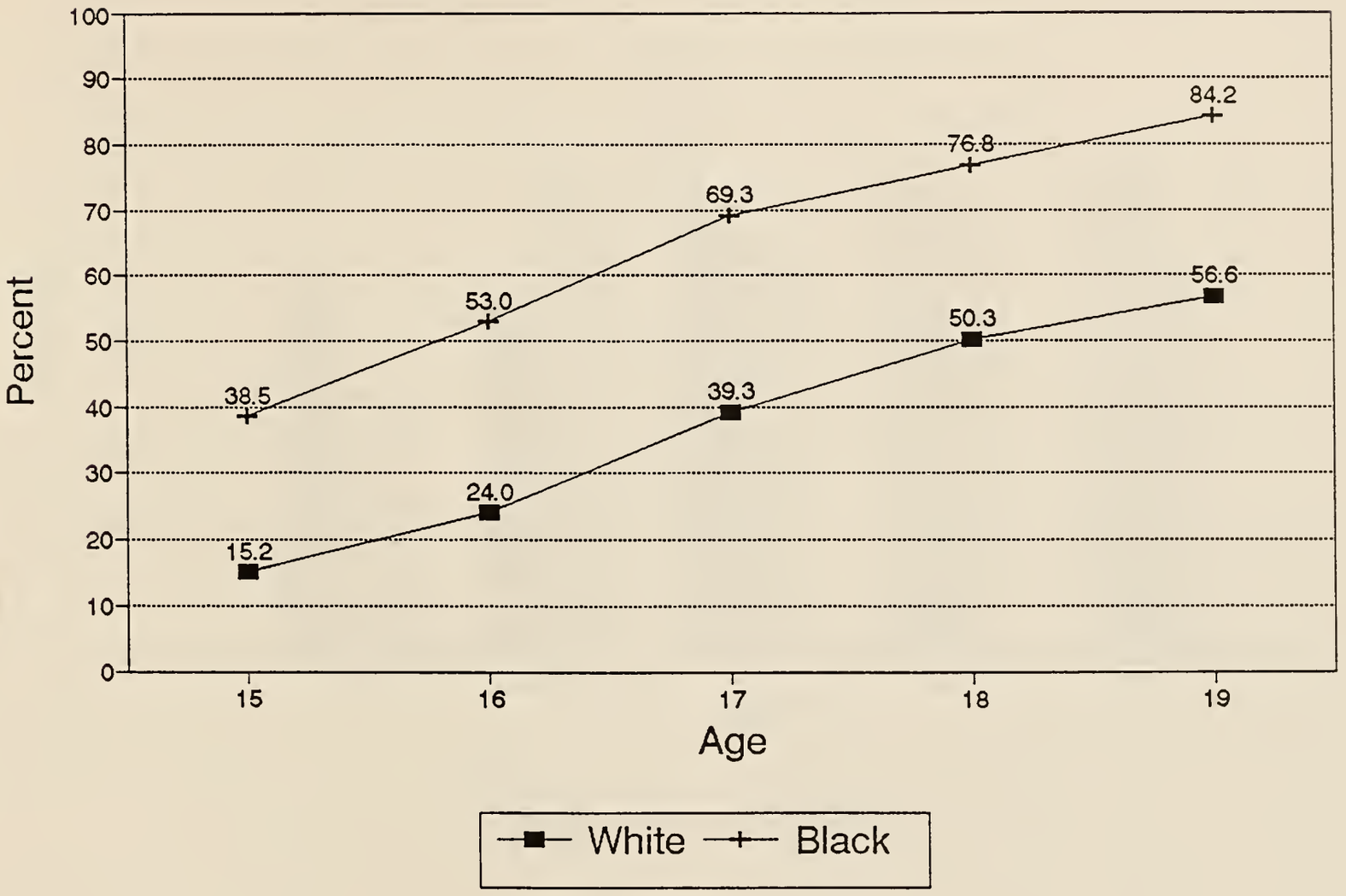
Health Status of Adolescent Males Ages 12-17 Years, United States: 1985-1986



Source: Wallace HM, Ryan G Jr., Oglesby AC. "Maternal and Child Health Practices," Third Edition, Third Party Publishing Company, 1988, Tbl 6, p. 528

Figure 3.3.3

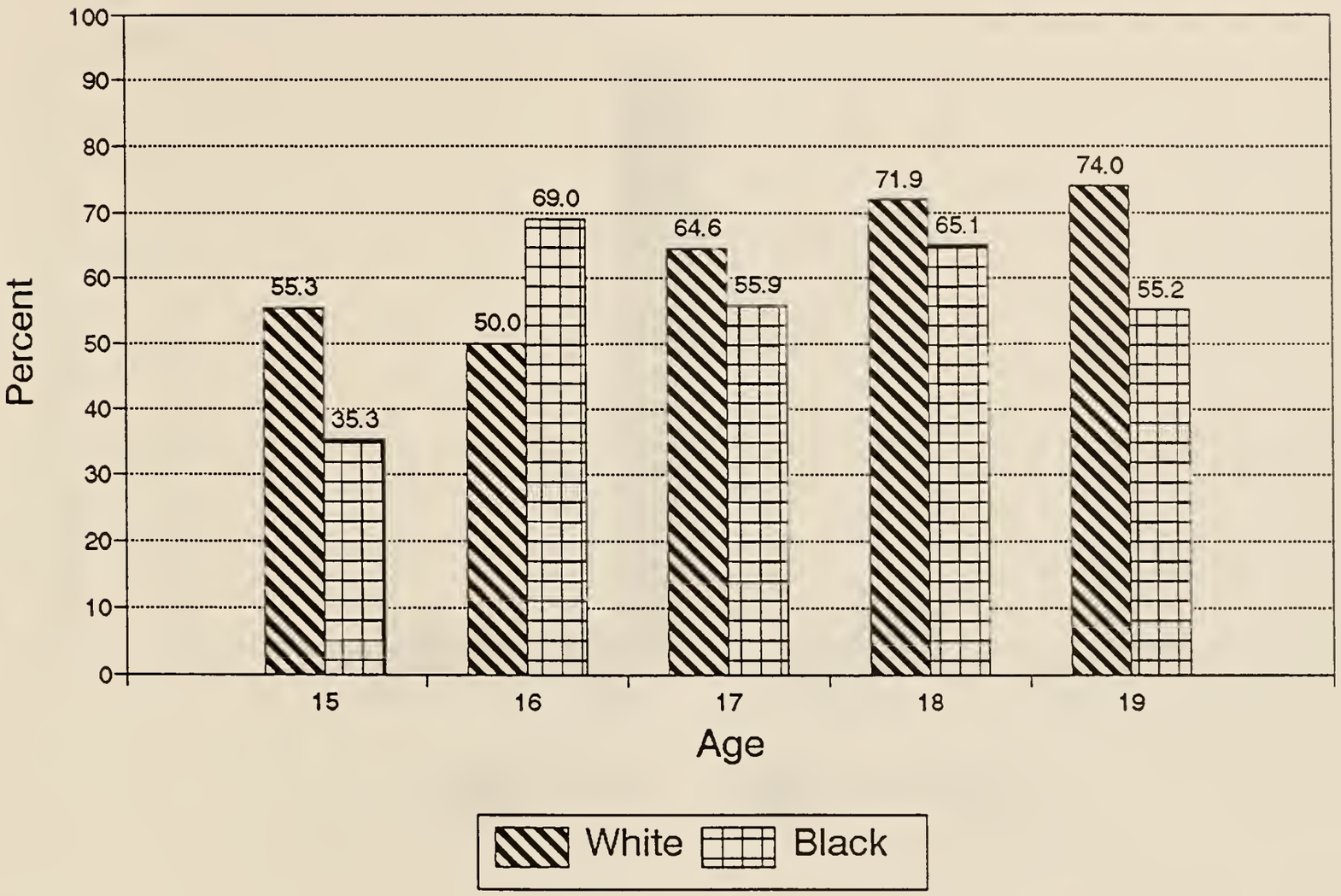
Premarital Intercourse Among Teenagers Ages 15 to 19, by Race, United States: 1981



Source: Boone MS. "Capital Crime: Black Infant Mortality in America," Sage Publications, Inc. 1989, p. 102

Figure 3.3.4

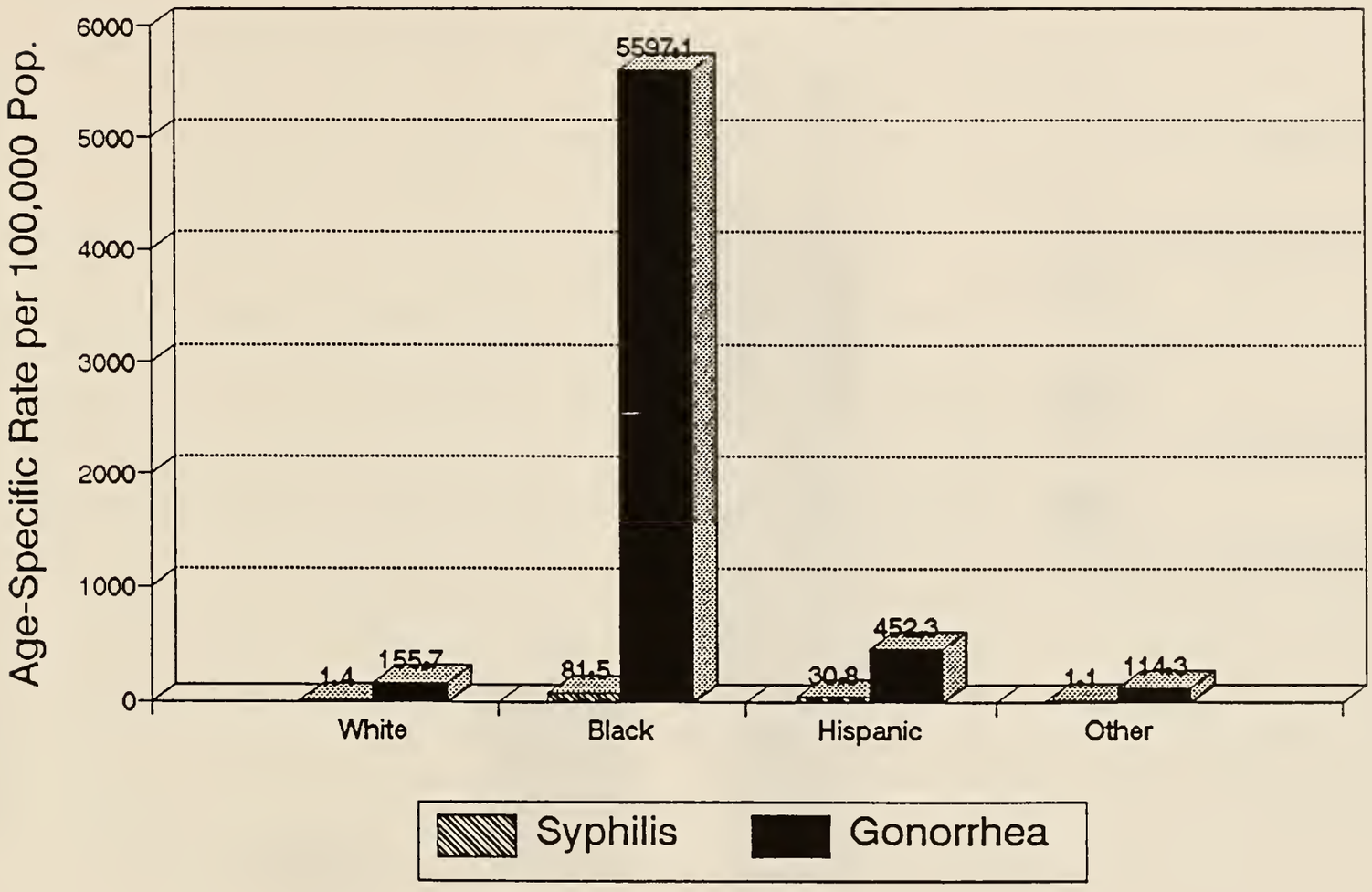
Percent of Never-Married Teenagers Ages 15 to 19 Using Contraception at Last Intercourse, by Race, United States: 1981



Source: Boone MS. "Capital Crime: Black Infant Mortality in America," Sage Publications, Inc. 1989, p. 102

Figure 3.3.5

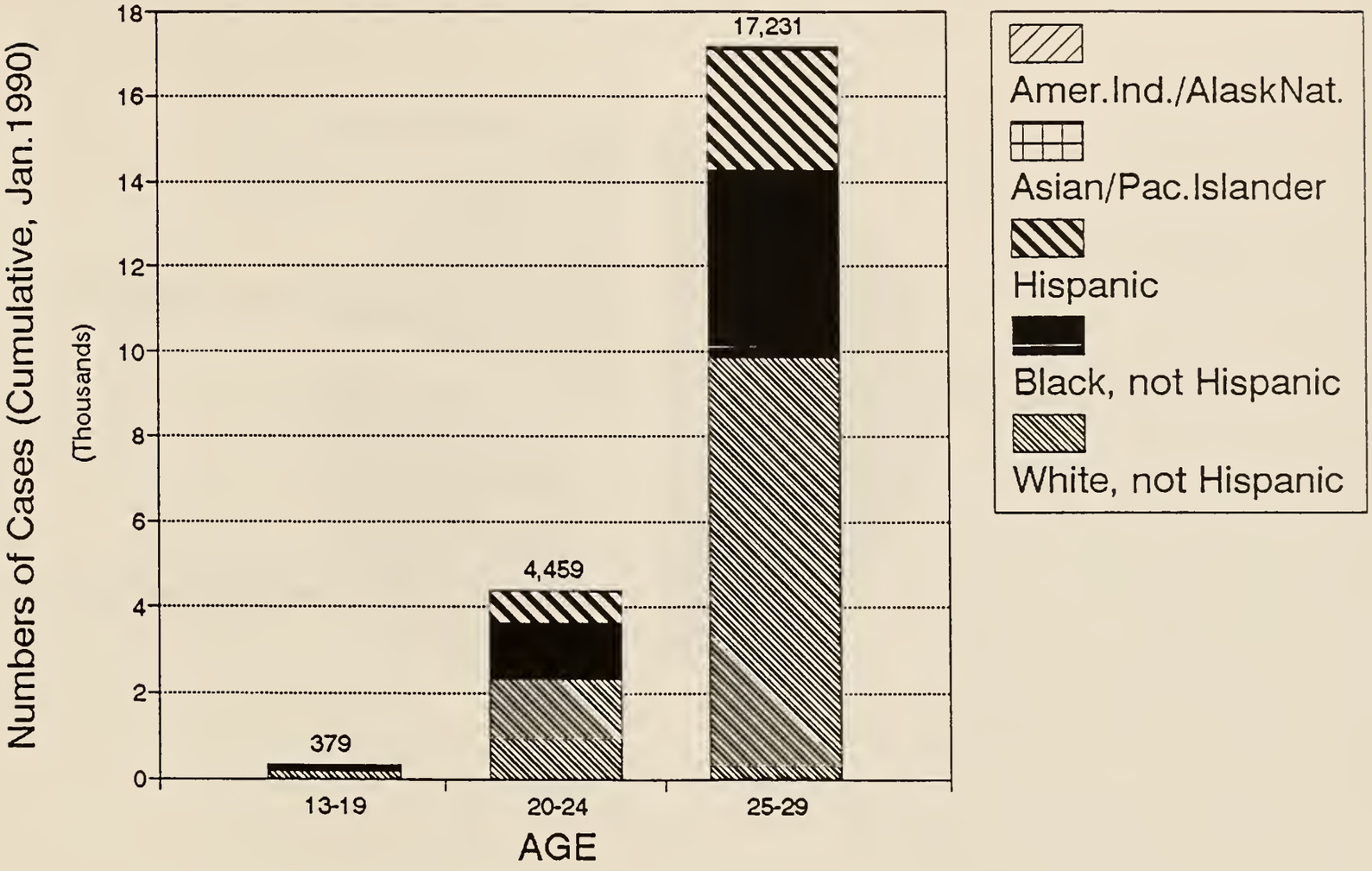
Age-Specific Case Rates of Gonorrhea and Primary and Secondary Syphilis Among U.S. Males 15-19 Years of Age, By Race (rates per 100,000 population), 1988



Source: Prepared by Policy Research Incorporated based on data presented in Table 3.3-4

Figure 3.3.6

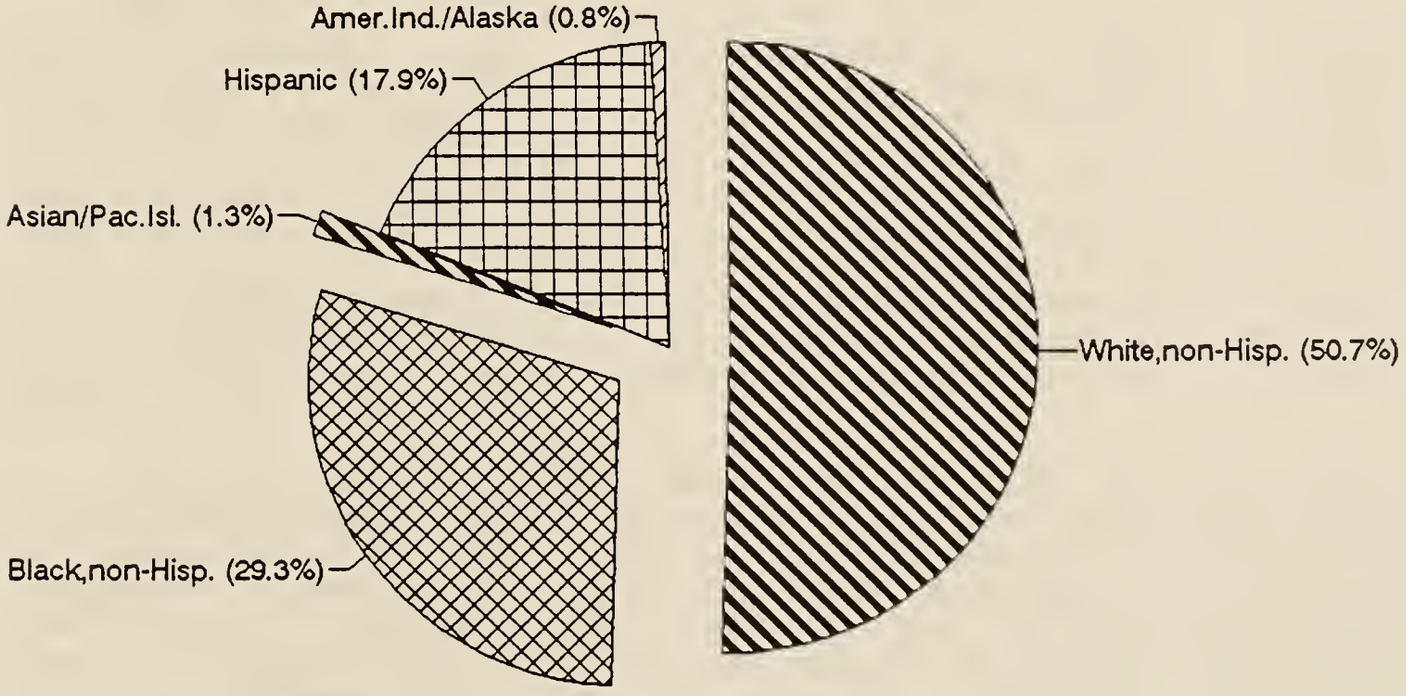
Cumulative Diagnosed Cases of Aquired Immunodeficiency Syndrome Among U.S. Males Ages 13-29, by Race and Hispanic Origin (through January, 1990)



Source: Prepared by Policy Research Incorporated based on data included in Table 3.3.4

Figure 3.3.7

AIDS Cases Diagnosed in Males Ages 13-19, Race/Ethnicity of 379 persons Diagnosed: United States, Reported through January 1990



Source: Centers for Disease Control. HIV/AIDS Surveillance Report, February 1990:1-18

3.4 ACUTE AND CHRONIC CONDITIONS

3.4.1 Overview

Chronic diseases, often manifested during adolescence, now constitute the leading causes of health problems and the leading causes of death in the United States. Moreover, certain categories of acute and chronic conditions, notably sexually transmitted diseases (discussed in section 3.7), hypertension, diabetes and tuberculosis, comprise important and growing causes of morbidity for minority adolescents.

This section reviews the available data on chronic and acute health problems that disproportionately affect minority adolescents, including tuberculosis, hypertension, chronic respiratory problems, lead poisoning, and sickle-cell anemia. Information on some conditions is available for only certain minority adolescent groups. National data on chronic and acute conditions are not available for adolescents specifically. The only available national data that approximate the prevalence of acute conditions among adolescents are school-loss days caused by acute conditions. These are reported for all school children from ages 5 to 17, and are not disaggregated further for adolescents ages 10 to 17.

This section also addresses acute and chronic mental health conditions among minority adolescent males, although the analysis is hampered by the fact that no epidemiological survey of the incidence of mental disorders has been conducted among minority adolescents. Moreover, the available data, drawn from smaller studies, suggest that biases are often associated with mental health diagnoses among minority patients. Finally, this section examines the use of inpatient psychiatric services by youth under age 18 in 1980 (the most recent year for which data is available).

3.4.2 Chronic and Acute Health Conditions that Affect Minority Adolescents

Sickle-cell anemia, which affects one in 600 Black Americans, may result in premature death.[1] Children with sickle-cell anemia have a variety of chronic and painful symptoms, including fevers, respiratory infections, arthritic pains, eye problems,[2] and progressive organ damage.[3] According to Carter,[3] because it is relatively rare and found primarily among Americans of African heritage, sickle-cell is often misdiagnosed and inappropriately treated, leading to premature death in some cases.

Tuberculosis, commonly thought to be a disease of the past, has reemerged among Black Americans, especially those 35 and under.[4] The ratio of tuberculosis morbidity rates for non-Whites compared with those for Whites steadily increased from 2.9 in 1953 to 5.2 in 1985. Tuberculosis is generally associated with crowded

conditions and poor health care, but it is largely preventable.[5] In 1985, the tuberculosis morbidity rate among Black males ages 15 to 24 was 10.8/100,000 compared to 2.6/100,000 among White males in the same age group.[6] Young Black males were thus four times as likely to contract tuberculosis as their White counterparts. The mortality differential was equally disparate. In 1985, the relative risk of death from tuberculosis among adolescent and young adult Black males compared to White males in this age group was 4.2. Although a considerable portion of minority populations with tuberculosis are also HIV seropositive, the relationship between tuberculosis and AIDS remains unclear.[7]

Hypertension is another serious chronic condition that disproportionately affects Black Americans. Hypertension occurs in approximately 25% of all Black Americans, compared to 16% of all Whites.[8] Race differences begin early in life, since studies have shown that blood pressure in Black adolescents is significantly higher than in White adolescents.[9] Johnson[10] found that Black adolescents were more likely to have a family history of hypertension compared to their White counterparts. His study examined psychological risk factors and found that emotional factors -- suppressed anger in particular -- were more common among Black adolescents and were significantly related to their elevated blood pressure. A study of older Black college students also indicated that suppressed anger, thought to be largely a product of cumulative racism, may be responsible for the higher incidence of hypertension among young adult Black Americans.[11] Hypertension is a risk factor for cardiovascular disease, the fifth leading cause of death for Black adolescent males. Although data regarding the incidence of hypertension among adolescent Hispanics is available from the 1982-1983 Hispanic Health and Nutrition Examination Survey (HHANES), it had not been analyzed to date.

Chronic diseases, especially diabetes and end-stage renal disease (ESRD), are major public health problems for Native Americans. Diabetes has become a major source of morbidity and mortality in most Native American populations.[12] Moreover, full-heritage Native American males ages 20 to 29 had an incidence rate of diabetes that was twice as high as Indian males of the same age who were half-Native American.[13] Obesity appears to be a significant factor in the excess of diabetes among this population. Diabetes is also often a major risk factor for end stage renal disease. The rate ratio of the annual incidence of ESRD among Native Americans and Whites ages 15 to 24 during this time interval was 1.3.[14]

To determine the characteristics and health care needs of disabled adolescents, Newacheck examined data from the 1984 National Health Interview Survey.[15] Nearly two million adolescents ages 10 to 18 years had some degree of limitation in their activities because of chronic conditions in 1984. These disabled persons accounted for 6.2% of the total noninstitutionalized

adolescent population. The leading causes of disability among adolescents ages 10 to 18 in 1984 were mental disorders, diseases of the respiratory system, diseases of the musculoskeletal system and connective tissue, and diseases of the nervous system.

As Table 3.4.1 shows, the prevalence of disability was found to vary by gender of the adolescent and income level and education of the adult reference person. Younger adolescents have a higher prevalence of disability than older adolescents, and adolescent males are much more likely than females to be disabled. Race or ethnicity does not appear to be a significant factor. There are significant differences according to income level, however -- the prevalence of disability for adolescents below the poverty level was 8.6/100, compared to 5.9/100 for adolescents above the poverty level. Large differences are also apparent according to educational attainment; adolescents in families where the adult reference person had completed less than nine years of education were 90% more likely to be disabled than adolescents from families where the reference person had completed 16 or more years of education.

Lead poisoning is another health problem that disproportionately affects low-income children. Lead contamination is most prevalent in the inner cities, originating mainly from chipped and flaking housepaint in older homes. The National Health and Nutrition Examination Survey II (NHANES II) estimated that 4% of all American children had blood lead levels above the toxic threshold compared to 18% for poor Black children.[16] In July 1988, a landmark study on lead poisoning found that 44% of urban Black children are at risk from lead poisoning -- four times the rate of urban White children.[17] Other studies have suggested that the risk of lead poisoning increases for minority children because the deficiency of iron, calcium, and other nutrients may raise the rate of lead absorption and retention.[18]

Needleman et al.[19] studied a group of children who were diagnosed with lead poisoning between 1975 and 1978; the mean length of follow-up was 11 years. This extensive study showed that the associations between lead and children's academic progress and cognitive functioning persisted into young adulthood. According to Needleman, "The persistent toxicity of lead was seen to result in significant and serious impairment of academic success, specifically a seven-fold increase in failure to graduate from high school, lower class standing, greater absenteeism, impairment of reading skills sufficiently extensive to be labeled reading disability (indicated by scores two grades below the expected scores), and deficits in vocabulary, fine motor skills, reaction time, and hand-eye coordination."[20] Early lead exposure was also associated with self-reports of minor delinquent activity.[21]

3.4.3 Limited Activity due to Acute Conditions

The only national measure of the prevalence of acute conditions among adolescents is the number of school days lost due to acute conditions. For instance, Table 3.4.2 shows the number of school days lost due to acute health conditions such as respiratory conditions, infective or parasitic conditions and injuries. White children ages 5 to 17 had significantly more school-loss days compared to Black children in the same age group. Black children were more likely than White children to miss school for the common cold.

The racial differences in overall school-loss days may result from variation in perceived severity of adolescent illness as well as in the availability of day care services or facilities. Since Black adolescents are disproportionately represented among the most impoverished youth, it is surprising that while Black youth had much fewer school-loss days compared to Whites, school-loss days are inversely related to income status (Table 3.4.2). This incongruity might be partially explained by the fact that for Black youth, every category in this table has a relative standard error of more than 30% due to insufficient data; the same is true for many of categories for White youth.

3.4.4 Mental Health

It is difficult to arrive at precise estimates of the incidence of mental disorders among minority adolescents because no epidemiological surveys of this group have been conducted.[22] Furthermore, there is a lack of consensus regarding the definition of youth's mental disorders; one major issue is distinguishing transient changes during adolescence from clinical disorders that warrant treatment,[23] and another is has to do with whether racial or socioeconomic differences are the primary associated factors. Warheit et al.[24] found that the differences in mental health scores between Black and White youth were largely insignificant when variables such as age and socioeconomic status were controlled. Accurate estimates of mental disorders among minority adolescents are also difficult to obtain since these estimates are often associated with biases in diagnosing minority patients.[25] It has been noted that Black patients are disproportionately diagnosed with psychoses and under-diagnosed with depression.[26] In looking at the difference in diagnostic patterns between White and nonWhite patients at outpatient clinics, Cannon and Locke found that in both 1961 and 1969, nonWhites of all ages were assigned more serious diagnoses than Whites.[27]

The relationship between health and mental health is very important in understanding the mental health problems and needs of minority adolescents. As this report has shown, the health risks associated with poverty, such as, poor nutrition, substandard housing, lack of adequate health care, are exacerbated for

adolescent minority males by behavioral risks associated with living in the inner-city. These behavioral risks include delinquency, substance abuse, and violence. As a result of these behavior patterns and poor environmental conditions, young minority males are particularly vulnerable to negative mental health outcomes which are related to low self-esteem, psychiatric disorders, and drug addiction.[28]

The few existing studies on mental health disorders suggest that low socioeconomic status may be a risk factor for adolescent depression.[29] [30] One study has estimated that the rate of serious depression in low-income Black adolescents may be as high as 15%.[31] Other studies have also shown that higher rates of depression have generally been found among male and low-income Black adolescents.[32] [33] The causes of depression are very important because suicide is the second leading cause of death among all adolescents and has increased dramatically among minority adolescents in the last three decades (see Section 3.2).

Black Americans exhibiting the same symptoms as Whites are more likely to be diagnosed with more serious conditions such as affective disorders, schizophrenia, and personality disorders.[34] Black males in public institutions were six times as likely as White males to receive a diagnosis of schizophrenia or some other severe disorder.[35] Overall, Black adolescents are at least twice as likely to be hospitalized for psychiatric conditions than White adolescents.[36]

Suicide is increasing among Black adolescents and now ranks as the third leading cause of death for Black males ages 15 to 24. Between 1960 and 1984, the suicide rate for Black males in this age group nearly tripled, from 4.1/100,000 to 11.2/100,000.[37] According to Gibbs, "the symptoms of suicidal behavior in Black youth are often masked by acting-out and high-risk behaviors, making it more difficult for clinicians to assess suicidal intent. Consequently, it is essential for clinicians to recognize 'depressive equivalents' and high-risk behaviors as potential clues to suicidal behavior in Black youth and to conduct a suicide assessment whenever these symptoms are chronic or severe." [38]

A recent Congressional Office of Technology Assessment study of the mental health needs of Native American adolescents[39] found serious mental health problems in the following areas: depression; suicide; anxiety; alcohol and substance abuse; self-esteem; and developmental disabilities. The authors note that "while the causes of mental health problems are not known with certainty, the life situations of many Indian adolescents are filled with stressors that can lead to emotional distress and serious mental and behavioral problems."[40] Their analysis confirms numerous earlier studies[41] [42] that have noted problems of abuse, neglect, excessive foster care placements, school delinquency, and suicide among Native American youth. Boyce and Boyce have found[43] that

among male and female Navajo adolescents, there is a trend toward increased mental health clinic visits among those who have a different cultural identity compared to their surrounding community.

The high incidence of alcohol and drug abuse among Native American youth is a fundamental problem with critical consequences.[44] As indicated in Section 3.5, Substance Abuse, Native American youth utilize alcohol and marijuana at rates three and two times as high, respectively, as those of adolescents in the population at large. According to LaFromboise and Low, "Substance abuse is a widely modeled means of coping with depression, anxiety, hostility, feelings of hopelessness, and stress reactions among Indian youth."[45] In addition to excessive alcohol and other drug use, the extremely high rates of suicide among Native American youth (presented in Section 3.2, Mortality) attest to their mental health problems and, particularly in the case of suicide, unmet mental health needs.

Although Mexican American adolescents are one of the most rapidly growing groups in the Southwest area, little is known about their mental health needs. In the absence of any systematic epidemiological studies, incidence rates of psychological disorders can be estimated from clinic-based research. In one study of Mexican American children and adolescents, matched for sex and family income with an Anglo comparison group, ethnic differences in the expression of behavior problems were evident.[46] Mexican American adolescent males were more frequently described as more aggressive and "acting out," while Anglo adolescent males were more often described as neurotic. The mental health providers in this study also reported that Mexican American youth generally benefited less from treatment compared to their Anglo counterparts. Other research has concluded that Hispanic adolescents with physical or psychological problems are particularly vulnerable to drug use compared with their Anglo peers.[47] More research is needed with regard to the various complexities of acculturation within the family and especially the intergenerational conflicts produced by the quicker adaptation of children and adolescents compared to their parents.

Despite the common notion that Asian Americans have adjusted very successfully in the United States, mental health problems have been encountered by many recent Asian immigrant populations. The few existing studies on mental health indicate that Asian Americans have high unmet mental health needs.[48] Studies of college students indicate that major adjustment problems are experienced by Asian American students.[49] Research has also shown that Asian Americans tend to significantly underutilize mental health services and, once in treatment, that they show high levels of disturbance and terminate therapy prematurely.[50 51] Cultural factors, such as shame and stigma on the family that are attached to mental health disorders, are important in explaining the underutilization of

mental health services by Asian American adolescents.[52]

Certain groups such as Southeast Asian refugees and immigrants have extremely high levels of depression and other mental disorders in comparison to the U.S. population as a whole.[53] The stress associated with immigration and refugee status has caused or exacerbated the health and mental health problems of many recently arrived Asian adolescents. In addition to numerous health problems, e.g., hepatitis B,[54] a major risk factor for other liver disease, Asian immigrant adolescents face serious mental health disorders. For example, as a result of their traumatic migration and resettlement camp experiences, many adolescent refugees suffer from delayed onset of chronic Post Traumatic Stress Disorder syndromes and depressive disorders.[55] According to mental health providers, these disorders often initially manifest themselves as physical and medical complaints. A 1986-87 study of the mental health needs of Southeast Asian groups in California indicated that in Los Angeles County, over one-third of the Vietnamese community comprised of both adults and adolescents, had a moderate or severe need for mental health treatment and 57% needed preventive consultation and educational services concerning mental health.[56]

3.4.4.1 Use of Inpatient Psychiatric Services

The use of inpatient psychiatric services by youth under age 18 was examined utilizing findings from three sample surveys of admissions during 1980 to the inpatient psychiatric services of state and mental county hospitals and private psychiatric hospitals, and the inpatient psychiatric services of non-Federal general hospitals.[57] The results from a similar although smaller survey conducted by the National Institute of Mental Health (NIMH) in 1986 are not available for analysis.[58] According to the 1980 survey, an estimated 81,532 persons under age 18 -- 95% between the ages of 10 and 17 -- were admitted to inpatient psychiatric care in these three settings during 1980.

The overall rate of admissions per 100,000 population under age 18 did not differ significantly by race in 1980. In other words, White and minority youth are represented as inpatients in psychiatric facilities according to their population representation. Within each type of inpatient psychiatric service surveyed however, large racial differences were observed. Children and youth under age 18 who were nonWhite were more likely to be admitted to state and county mental hospitals and public non-Federal general hospitals than to private hospitals (Figure 3.4.1). Twenty-nine percent of all admissions for nonWhite youth under age 18 were to state and county mental hospitals, compared to 14% to private psychiatric hospitals, and 58% to general hospitals.

With respect to diagnostic variation by race among youth, significant differences were found between Whites and nonWhites

(Figure 3.4.2). For all inpatient psychiatric services combined, the leading three diagnoses for White youth were nonpsychotic disorders, pre-adult disorders, and affective disorders. Among Black youth, the leading diagnoses in 1980 were: schizophrenia, affective disorders and pre-adult disorders. (The definition of each diagnostic grouping is presented in Table 3.4.3.) Moreover, nonWhite youths were twice as likely to be diagnosed as schizophrenic compared to White youths in all institutions (20.5% vs. 10.0%) and almost five times as likely to be diagnosed as schizophrenic in state and county mental hospitals (33.7 vs. 6.4).

The children and youth admitted to inpatient psychiatric services during 1980 were referred for care by a number of different types of persons or agencies (Figure 3.4.3). Referral patterns did not differ significantly by race with the exception of referrals from private psychiatrists. White youth were more than twice as likely to be referred for inpatient psychiatric services by a private psychiatrist compared with Black youth. Among White youth, referrals were most likely to come from friends and family or private psychiatrists. The rate of referrals from family and friends was almost the same for nonWhite youth as for White youth (23.9% and 26.4%, respectively). Fifteen percent of all referrals for admissions to state and county mental hospitals among all youth under age 18 were referrals from courts or correction agencies (Figure 3.4.3).

Figure 3.4.4 presents the types of treatment for persons under age 18 admitted to inpatient psychiatric services in 1980. For both White and nonWhite youth, the three leading types of treatment provided during psychiatric hospitalization were: individual therapy, activity therapies, and group therapy. The most salient variation in treatment between Whites and minority youth was found in state and county hospitals, where nonWhites were almost twice as likely as Whites to receive drug therapy (63% vs. 36%). However, at all psychiatric institutions, 51% of non-White inpatient youths versus 41% of inpatient White youth received drug therapy.

Table 3.4.1

Prevalence of Disability According to Sociodemographic Characteristics for Adolescents 10 to 18 Years of Age: United States, 1984*

Sociodemographic Characteristic	Prevalence (per 100)
Age (y)	
10–14	6.6
15–18	5.7
10–18	6.2
Gender	
M	7.2
F	5.2
Race and ethnicity	
White, not Hispanic	6.2
Black, not Hispanic	6.2
Hispanic	6.7
Other	5.5
Poverty Status†	
Above poverty level	5.9
Below poverty level	8.6
Education of family reference person (y)	
<9	9.7
9–11	8.2
12	6.2
13–15	5.4
>16	5.1
Region	
Northeast	6.0
Midwest	6.3
South	6.5
West	6.0
Residence	
Metropolitan	6.3
Nonmetropolitan	6.0

* Original tabulations from public use tapes, National Health Interview Survey.
† Persons with unknown family income excluded.

Source: Paul W. Newacheck, Dr PH, "Adolescents With Special Health Needs: Prevalence, Severity, and Access to Health Services," Pediatrics, Vol. 84, No. 5, Nov 1989

Table 3.4.2

Number of School-Loss Data Associated with Acute Conditions per 100 Youths 5-17 Years of Age, by Sex, Race, Family Income, and Type of Condition: United States, 1988

DATA ARE BASED ON HOUSEHOLD INTERVIEWS OF THE CIVILIAN NONINSTITUTIONALIZED POPULATION.

TYPE OF ACUTE CONDITION	ALL AGES 5-17 YEARS	SEX		RACE		FAMILY INCOME			
		MALE	FEMALE	WHITE	BLACK	LESS THAN $10,000	$10,000-$19,999	$20,000-$34,999	$35,000 OR MORE
	NUMBER OF SCHOOL-LOSS DAYS PER 100 YOUTHS PER YEAR								
ALL ACUTE CONDITIONS	405.9	379.0	433.4	427.2	322.0	538.5	417.9	390.4	382.7
INFECTIVE AND PARASITIC DISEASES	106.5	97.0	115.8	113.1	97.1	150.8	100.4	89.5	114.2
COMMON CHILDHOOD DISEASES	33.5	33.0	33.5	31.8	*50.4	*71.1	*47.4	*23.9	*21.8
INTESTINAL VIRUS, UNSPECIFIED	10.7	*10.1	*11.3	11.0	*8.4	*9.9	*5.7	*16.7	*10.5
VIRAL INFECTIONS, UNSPECIFIED	20.4	*15.9	25.0	21.7	*18.0	*33.2	*19.1	*13.8	*23.7
OTHER	41.9	38.0	45.9	47.8	*20.2	*36.7	*28.3	35.0	58.2
RESPIRATORY CONDITIONS	217.2	203.8	231.2	230.8	147.8	253.7	215.8	220.4	204.8
COMMON COLD	57.8	49.1	66.9	56.2	63.1	85.9	67.7	55.1	40.0
OTHER ACUTE UPPER RESPIRATORY INFECTIONS	26.2	26.0	26.5	29.7	*13.1	*34.7	*19.8	*24.0	28.2
INFLUENZA	113.1	108.7	117.7	123.3	61.4	121.5	116.8	121.9	113.1
ACUTE BRONCHITIS	10.8	*8.9	*12.8	11.0	*5.7	*10.4	*9.4	*10.1	*11.2
PNEUMONIA	*6.4	*8.3	*4.4	*7.5	*2.4	*-	*-	*4.8	*10.3
OTHER RESPIRATORY CONDITIONS	*2.8	*2.8	*2.8	*3.0	*2.2	*1.1	*2.0	*4.0	*1.3
DIGESTIVE SYSTEM CONDITIONS	14.4	*12.2	*16.7	14.1	*16.7	*12.5	*14.7	*11.3	*15.1
DENTAL CONDITIONS	*1.6	*1.8	*1.4	*1.7	*1.3	*4.0	*1.4	*2.1	*0.3
INDIGESTION, NAUSEA, AND VOMITING	*7.8	*7.3	*8.3	*7.0	*11.1	*7.9	*8.4	*8.8	*5.3
OTHER DIGESTIVE CONDITIONS	*5.0	*3.0	*7.1	*5.3	*4.2	*-	*4.8	*0.5	*9.4
INJURIES	26.6	35.6	*17.1	28.4	*20.6	*47.3	*18.3	*31.1	*20.4
FRACTURES AND DISLOCATIONS	*7.5	*12.9	*1.8	*7.5	*9.1	*21.4	*0.7	*5.6	*7.6
SPRAINS AND STRAINS	*4.2	*4.3	*4.1	*4.5	*3.7	*3.8	*3.4	*7.3	*3.1
OPEN WOUNDS AND LACERATIONS	*4.0	*6.0	*3.1	*5.1	*3.3	*8.3	*1.9	*6.6	*3.1
CONTUSIONS AND SUPERFICIAL INJURIES	*3.2	*2.6	*3.8	*3.7	*1.3	*7.7	*1.9	*4.0	*2.5
OTHER CURRENT INJURIES	*7.1	*9.8	*4.3	*7.6	*3.2	*6.1	*10.4	*7.1	*4.1
SELECTED OTHER ACUTE CONDITIONS	33.7	26.2	41.0	32.9	*32.4	*58.5	59.2	*29.8	*25.8
EYE CONDITIONS	*1.4	*1.2	*1.0	*1.4	*0.5	*4.0	*2.4	*-	*1.4
ACUTE EAR INFECTIONS	12.1	*14.4	*9.0	13.8	*5.7	*14.7	*17.1	*11.5	*12.8
OTHER EAR CONDITIONS	*0.9	*0.2	*1.6	*0.9	*0.7	*-	*2.7	*-	*1.3
ACUTE URINARY CONDITIONS	*2.7	*0.7	*4.9	*2.4	*4.8	*7.3	*4.5	*2.2	*1.7
DISORDERS OF MENSTRUATION	*0.8	...	*1.7	*0.7	*0.4	*2.3	*2.2	*-	*0.3
OTHER DISORDERS OF FEMALE GENITAL TRACT	*0.2	...	*0.4	*-	*1.2	*1.6	*-	*-	*-
DELIVERY AND OTHER CONDITIONS OF PREGNANCY AND PUERPERIUM	*4.3	...	*8.9	*2.0	*11.4	*7.0	*15.9	*3.5	*-
SKIN CONDITIONS	*2.8	*4.6	*0.8	*3.3	*0.8	*1.9	*3.3	*1.1	*4.9
ACUTE MUSCULOSKELETAL CONDITIONS	*0.8	*0.5	*1.1	*0.6	*0.3	*2.3	*-	*0.8	*0.7
HEADACHE, EXCLUDING MIGRAINE	*4.0	*2.4	*5.7	*3.7	*4.7	*14.2	*9.9	*1.2	*1.0
FEVER, UNSPECIFIED	*3.8	*2.3	*5.4	*4.1	*1.7	*3.1	*1.1	*9.4	*1.7
ALL OTHER ACUTE CONDITIONS	*7.6	*4.2	*11.1	*7.9	*7.5	*15.8	*9.6	*8.3	*2.5

*Estimates for which the numerator has a relative standard error of more than 30 percent.

Source: National Center for Health Statistics. Current Estimates from the National Health Interview Survey, 1988. DHHS Pub. No. (PHS) 89-1501, Series 10, No. 173, Oct. 1989, Tbl 46

Table 3.4.3

PERCENT DISTRIBUTION OF ADMISSIONS UNDER AGE 18 TO SELECTED INPATIENT PSYCHIATRIC SERVICES, BY RACE AND SELECTED PRIMARY DIAGNOSES: UNITED STATES, 1980

Race and selected primary diagnoses	Inpatient psychiatric services			
	Total	State and county mental hospitals	Private psychiatric hospitals	Non-Federal general hospitals
White	66,938	12,432	14,735	39,771
Alcohol-related disorders[1]	2.7%	8.4%	2.3%	1.1%
Drug-related disorders[2]	4.6	11.5	2.8	3.2
Affective disorders[3]	17.6	9.4	29.7	15.6
Schizophrenia and related disorders[4]	10.0	6.4	10.9	10.8
Personality disorders[5]	6.9	12.2	8.4	4.6
Pre-adult disorders[6]	23.5	28.4	27.1	20.7
Other nonpsychotic disorders[7]	26.3	14.3	14.3	34.6
Other[8]	9.3	9.3	4.6	9.4
All other races	14,594	4,180	2,000	8,414
Alcohol-related disorders[1]	*	*	*	*
Drug-related disorders[2]	*	*	*	*
Affective disorders[3]	19.6	9.8	29.1	22.2
Schizophrenia and related disorders[4]	20.5	33.7	25.2	12.7
Personality disorders[5]	7.9	*	7.2	10.0
Pre-adult disorders[6]	17.1	20.9	24.6	13.4
Other nonpsychotic disorders[7]	14.8	10.6	7.4	18.5
Other[8]	11.7	12.5	5.6	12.8

*Five or fewer sample cases; estimate not shown because it does not meet standards of reliability.

Note: Percentages may not add to 100% due to rounding.

[1]Alcoholic psychoses; Alcohol dependence syndrome; Alcohol abuse

[2]Drug psychoses, Drug dependence; Tobacco use disorder; Cannabis abuse; Hallucinogen abuse, Barbiturate and similarly acting sedative or hypnotic abuse; Opioid abuse; Cocaine abuse, Amphetamine or related acting sympathomimetic abuse; Antidepressant type abuse; Other, mixed, or unspecified drug abuse

[3]Affective psychoses; Depressive type psychosis; Neurotic depression

[4]Schizophrenic disorders; Psychoses with origin specific to childhood

[5]Personality disorders; Disorders of impulse control,not elsewhere classified

[6]Disturbance of conduct, not elsewhere classified; Overanxious disorder; Shyness disorder of childhood;Separation anxiety disorder; Hyperkinetic syndrome of childhood

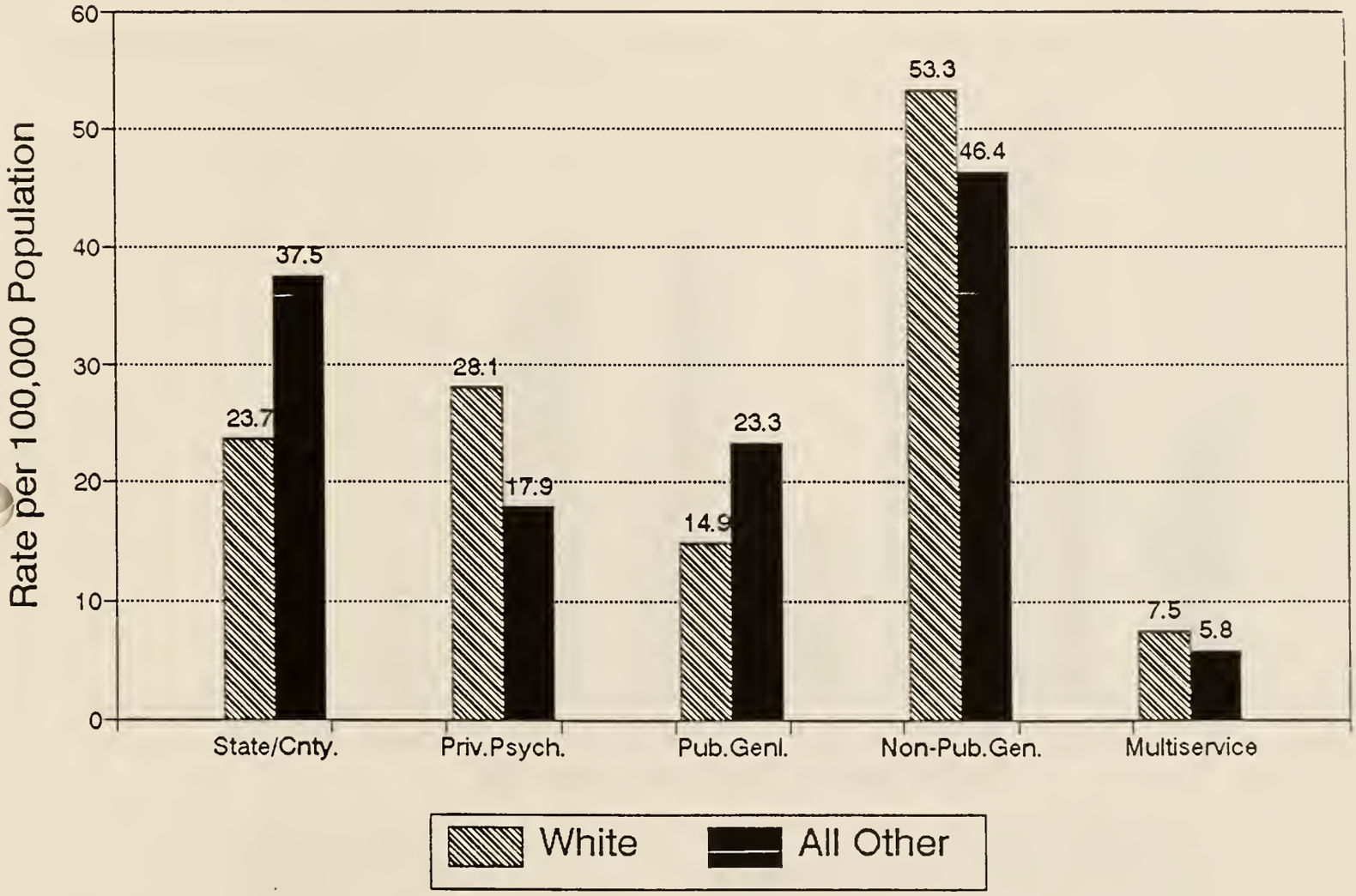
[7]Other (occupational neurosis, including writers' cramp, psychasthenia, psychasthenic neurosis); Unspecified neurotic disorder; Sexual deviations and disorders; Physiological malfunction arising from mental factors; Stammering and stuttering; Anorexia nervosa; Tics; Stereotyped repetitive movements; Somnambulism or night terrors; Other and unspecified disorders of eating; Enuresis; Encopresis; Other and unspecified special symptoms or syndromes, not elsewhere classified; Adjustment reaction; Depressive disorder, not elsewhere classified; Misery and unhappiness disorder; Introverted disorder of childhood; Relationship problems; Other or mixed emotional disturbances of childhood or adolescence; Unspecified emotional disturbance of childhood or adolescence; Specific delays in development; Psychic factors associated with diseases classified elsewhere

[8]Senile and presenile organic psychotic conditions; Transient organic psychotic conditions; Other organic psychotic conditions (chronic); Paranoid states; Excitative type psychosis; Reactive confusion, Acute paranoid reaction; Psychogenic paranoid psychosis; Other and unspecified reactive psychosis; Unspecified psychosis; Anxiety state, unspecified; Panic disorder; Generalized anxiety disorder; Other; Hysteria; Hysteria, unspecified, Conversion Disorder; Psychogenic amnesia; Psychogenic fugue; Multiple personality; Dissociative disorder or reaction, unspecified; Phobic disorders; Phobia, unspecified; Agoraphobia with panic attacks; Agoraphobia without mention of panic attacks; Social phobia; Other isolated or simple phobias; Obsessive-compulsive disorders; Neurasthenia; Depersonalizaton syndrome; Hypochondriasis; Other neurotic disorders; Somatization disorder; Specific disorders of sleep of nonorganic origin; Psychalgia; Acute reaction to stress; Prolonged posttraumatic stress disorder; Specific nonpsychotic mental disorders due to disorders due to organic brain damage; Mild mental retardation; Other specified mental retardation; Moderate mental retardation; Severe mental retardation; Profound mental retardation; Unspecified mental retardation; Other unknown and unspecified cause

Source: National Institute of Mental Health Statistical Note No. 175, Apr 1986, Tbl 6, p. 17.

Figure 3.4.1

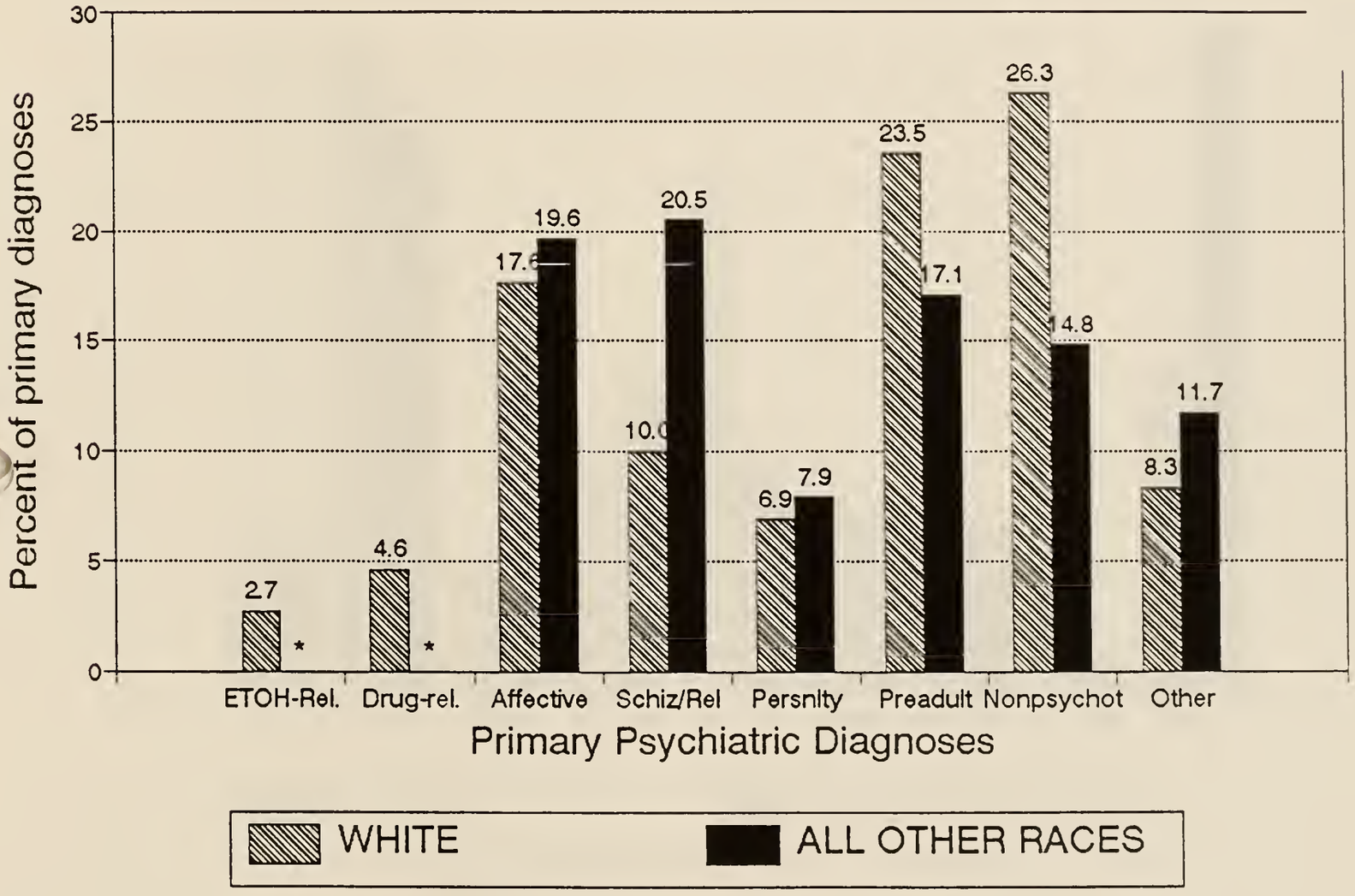
Rate per 100,000 Civilian Population of Admissions Under Age 18 to Selected Inpatient Psychiatric Services, By Race: United States, 1980



Source: National Institute of Mental Health Statistical Note No. 175, Apr 1986, Tbl 1, p. 12

Figure 3.4.2

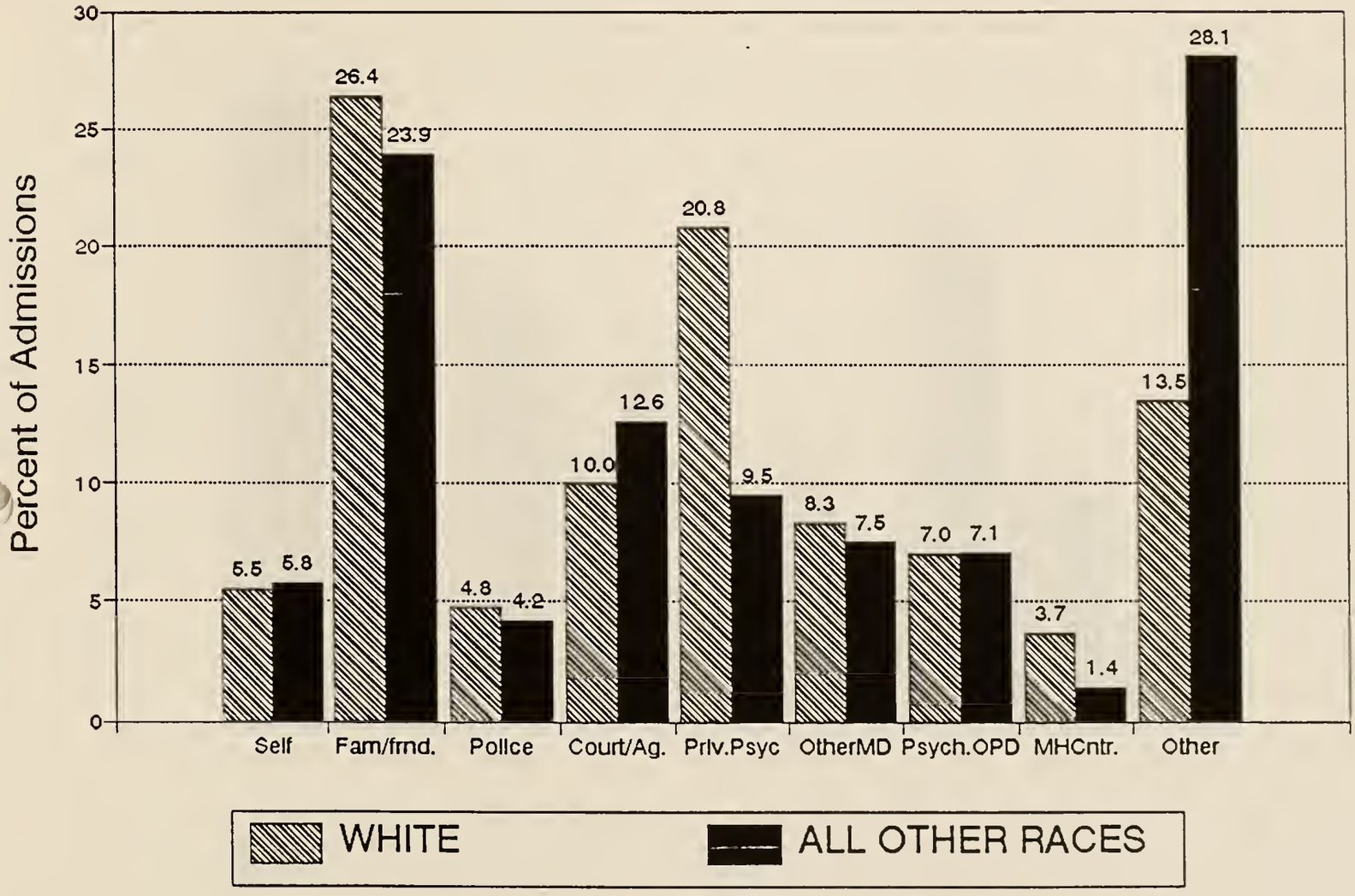
Percent Distribution of Admissions Under Age 18 to Selected Inpatient Psychiatric Services, By Race and Selected Primary Diagnoses: United States, 1980



Source: National Institute of Mental Health Statistical Note No. 175, Apr 1986, Tbl 6, p. 17

Figure 3.4.3

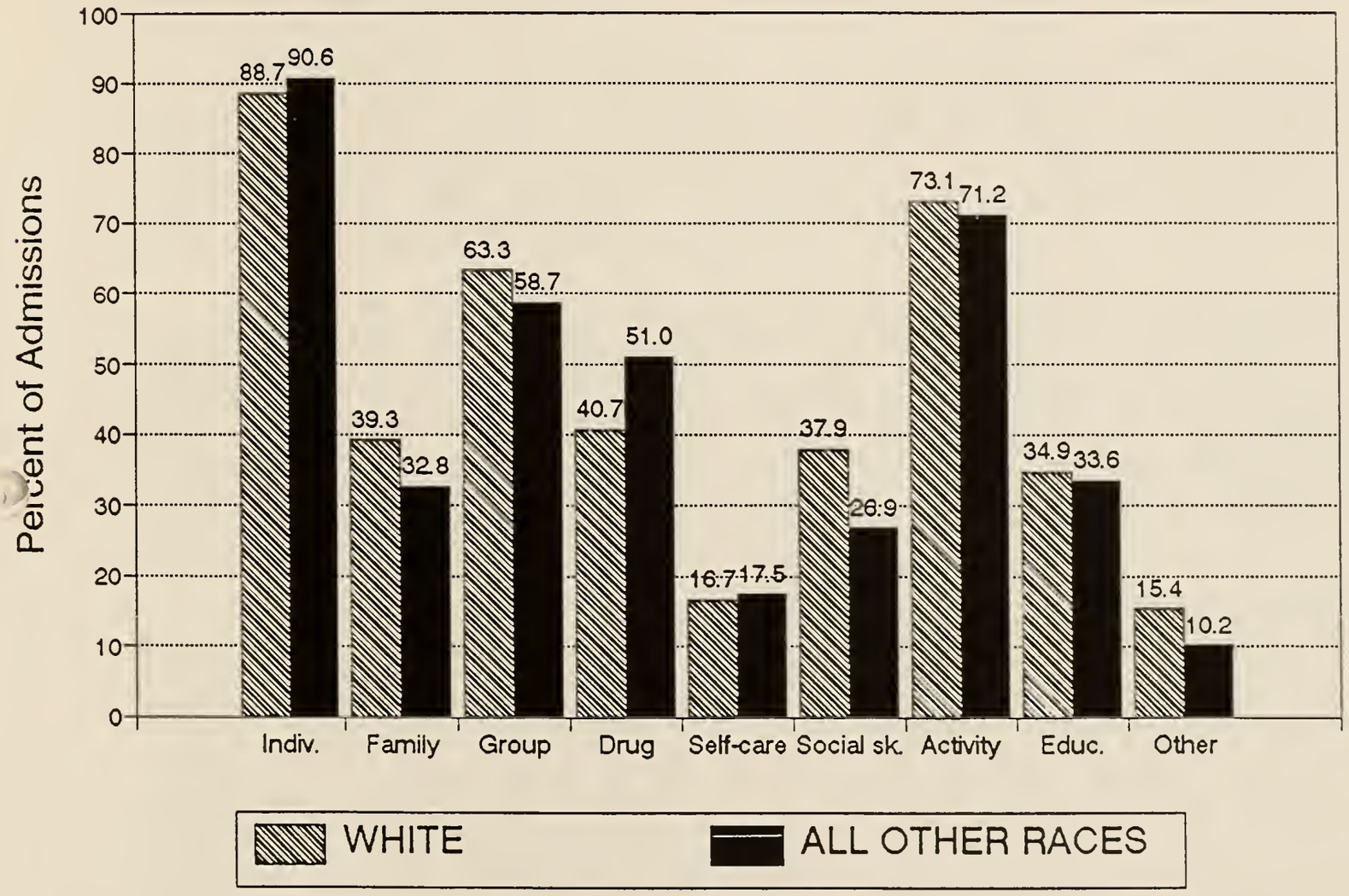
Percent Distribution of Admissions Under Age 18 to Selected Inpatient Psychiatric Services, By Race and Source of Referral: United States, 1980



Source: National Institute of Mental Health Statistical Note No. 175, Apr 1986, Tbl 9, p. 20

Figure 3.4.4

Percent Distribution of Admissions Under Age 18 to Selected Inpatient Psychiatric Services, By Race and Type of Treatment: United States, 1980



Source: National Institute of Mental Health Statistical Note No. 175, Apr 1986, Tbl 12, p. 23

3.5 SUBSTANCE ABUSE

3.5.1 Overview

Minority adolescents differ from White adolescents in their choice of drugs, in responses to intervention and treatment, and in their families' involvement in their treatment and recovery. In spite of widespread media attention to the proliferation of drug abuse, only minimal data are available which are disaggregated by race, ethnicity and age. This section presents available comparable data on substance abuse among minority adolescent males.

Alcohol and other drug abuse, as well as smoking, poor dietary intake and stress, are among the most salient preventable risk factors associated with the leading causes of death for minority adolescents and adults. Alcohol and drug abuse are inextricably linked with accidents, homicides and suicides -- leading causes of death among all adolescents. In recognition of the importance of this issue, substance abuse is treated separately in this section.

The abuse of illicit drugs is an important public health and social problem. Marijuana, the most frequently used illicit drug, exposes the adolescent smoker to more tar per "smoke" than high-tar cigarettes.[1] Cocaine use presents the risk of fatal overdose in some individuals and of profound dependency in most, with adverse consequences for functioning in many life areas.[2] Further, young users of drugs (including alcohol) expose themselves and others to hazards when they attempt to drive motor vehicles or operate machinery under the influence of drugs.

The National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the National Institute on Drug Abuse (NIDA) household surveys are the basis for most of the data reported in this section. However, while household surveys have consistently reported less alcohol and drug use among Black adolescents compared to White adolescents, data from drug-related hospital admissions, drug treatment programs and drug-related mortality statistics, present an entirely different picture, with an overrepresentation of Black and Hispanic adolescent males in all of these areas. The most recent (and widely cited) adolescent surveys on drug use may have clarified these conflicting findings, but unfortunately the data are not disaggregated by race or ethnicity.

Importantly, as these data will demonstrate, the types of drugs that minority males are using are more likely to result in disproportionate illness, injury and death than those used by White adolescent males.

3.5.2 Alcohol Consumption

Alcohol consumption is related to numerous adolescent health problems, particularly unintentional injuries, which is the leading

cause of death among White males ages 10 to 19 and the second leading cause among Black males in the same age group. It is estimated that there are 3.3 million problem drinkers under age 18;[3] it thus constitutes a public health and social problem of significant proportions. Drinking patterns differ according to sex, ethnicity, and social and cultural background, as reflected in findings from various data sources, such as household surveys, cause-specific mortality statistics, and treatment populations.

According to NIDA's 1988 National Household Survey on Drug Abuse with respect to alcohol use by adolescents. In all age groups, Black adolescents were less likely than White and Hispanic adolescents to report alcohol use in the month preceding the interview.[4] Among adolescents ages 12 to 17, Whites were 72% more likely to have reported alcohol use in the past month compared with Black adolescents. White and Hispanic adolescents reported similar drinking patterns. For young adults ages 18 to 25, Whites were 38% and 12% more likely, respectively, compared to Black and Hispanic young adults, to have reported alcohol use in the past month.

A nationwide survey[5] of 5,000 high school students in the 10th to 12th grades revealed that there were twice as many abstainers reported among Black students as among White students: 34% of all Black male students reported that they abstained compared to only 20% of all White students. There were four times as many heavy drinkers among White male students, with 16% drinking at least once a week and consuming five drinks or more on each occasion. Only 4% of Black students surveyed drank at this level. These survey results concur with past surveys of minority adolescent drinking behavior which suggest that heavy drinking is more common among Whites than among their minority adolescent counterparts.[6] School surveys and studies of non-student populations of high-school age have concluded that Black adolescents generally drink less than White adolescents and have fewer alcohol-related problems.[7]

These self-reported data suggest that alcohol-related diseases such as liver cirrhosis and esophageal cancer should be less prevalent among Black Americans than among the population in general. As Figure 3.5.1 shows, age-adjusted Black male death rates for all drug-related causes, including alcohol, were two and a half times those of White males in 1987. Moreover, they have been increasing significantly since 1979 (with the exception of 1983).

The Drug Abuse Warning Network (DAWN) collects data on drug abuse-related episodes from 738 hospital emergency rooms in 21 metropolitan areas and collects data on drug-related deaths from 87 medical examiners in 27 metropolitan areas.[8] Although the data are limited to certain locales where racial minority populations tend to be overrepresented, and cases are restricted to reported medical crisis episodes only, the DAWN tracking system is a useful and current source of information because it balances the

underreporting of drug use in household surveys. Although gender- and age-disaggredated data are not available from DAWN, Table 3.5.1 and Figure 3.5.2 show the percent distribution of drug mentions for selected drugs, including alcohol, for White, Black and Hispanic Americans. Thirty-seven percent of all "alcohol-in-combination" mentions were among Black emergency room patients in 1988 and 9% were among Hispanic patients, compared with 45% of White patients.

Disease-specific rates also point to serious alcoholism problems among Black males. For example, the rate of cirrhosis of the liver among Black Americans of all ages, especially Black men, is double that of Whites nationwide and in some cities is as high as 10 times the rate of Whites.[9] Black males have an extremely high incidence of cancer of the esophagus, with incidence rates several times higher than those for White males.[10] This type of cancer is considered to be strongly related to alcohol abuse.[11] Black males have the highest rates of hypertension,[12] which can be aggravated by alcohol consumption.[13] Since degenerative diseases associated with heavy alcohol use usually (but not invariably) develop over a period of years, the higher mortality rates for such diseases as cirrhosis of the liver and cancer of the esophagus among older Black Americans is relevant with respect to adolescent alcohol use. The conflict between the household survey drinking data and the related chronic disease data may result from an underestimate of alcohol use among minority adolescents by household surveys.

While survey results and other data are not unequivocal on Black and Hispanic adolescent drinking, there has been no such ambiguity concerning Native Americans. Studies indicate that Native American adolescents have extremely high rates of alcohol abuse and dependence and their associated problems. Overall, rates of alcohol abuse and alcoholism among young Native Americans are many times higher than for the general population. Concurrently, liver cirrhosis is the ninth leading cause of death among Native American males ages 15 to 24.[14] Between 1984 and 1985, deaths attributed to alcoholism were six times higher among adolescent and young adult Native American males compared to the U.S. all races population.[15]

One study, based on a large sample of secondary students in the State of New York, stated that "the magnitude of alcohol and drug use among 7-12th grade Native Americans [of both sexes] was striking. These young people average about two drinks a day, with 19% classified as heavy drinkers."[16] In a long-term project to assess the patterns of alcohol use among reservation youth over a 10-year period, alcohol use was determined to be a common element in the lives of Native American youth.[17] In 1982, 48% of all Native American 7th-12th graders had used alcohol in the preceding months. Native American students got drunk more often, drank more heavily, and blacked out more often than non-Indian students. Although the

age of first intoxication was similar for Indian and non-Indian students, Indian adolescents tended to become intoxicated more often after their initial experience. Once Indian youth enter adolescence, they tend to use alcohol and drugs in combination. Unfortunately, the data were not disaggregated by sex. The patterns described in the study were not isolated phenomena, but were relatively consistent over a 10-year period.[18]

A number of biologically and culturally based theories have been proposed to explain the exceptionally high rates of alcohol abuse and dependence among Native American youth.[19] No single theory however, appears to have gained widespread acceptance. According to NIAAA,

> "Of more than 280 diverse American Indian populations, some are characterized by binge drinking followed by periods of sobriety, while other groups remain almost totally abstinent. In still other populations, moderate drinking is the norm. Alcohol problems among American Indians appear to have a strong correlation with economic factors such as unemployment and low income levels and with marital and family instability."[20]

Since the early 1970s, information concerning alcohol use involving Asian Americans has been sparse and inconclusive.[21] Most researchers believe that alcohol consumption is low among this group and the related number of problems is less. There may be, however, significant deviations from this observation for certain groups of Asian Americans. A study of secondary students in the State of New York found that "drinking by Oriental youths is unique in that males drink heavily and females are light drinkers."[22] In fact, 12% of all male Oriental students surveyed reported being heavy drinkers compared to 29%, 21%, 11%, and 8% of Native American, White, Hispanic and Black males, respectively. The study also found that while Oriental males in secondary schools had a relatively high prevalence of heavy drinkers, they had a low percentage of overall drinkers.[23] Since this relationship is unique to Oriental adolescent males, further research is needed to substantiate and explain this phenomenon.

3.5.3 Abuse of Illicit Drugs

Abuse of and dependence on illicit drugs is a serious health problem that has had a devastating impact on adolescents and their families. Illicit drug use has resulted in widespread social repercussions, including an increase in crime and homicides, infant abandonment and child neglect, prostitution and adverse economic impacts on the communities most affected, especially inner-city minority areas.[24] [25] Adolescent drug involvement and adolescent pregnancy are independently major concerns to public health officials. Moreover, studies indicate a higher likelihood of sexual activity among adolescents who use drugs.[26] Frequent use and

abuse of drugs is also more common among adolescents who engage in chronic delinquent behavior than among other adolescents.[27] Recent data show a high frequency of co-dependencies among adolescents with substance abuse problems; for example, adolescents who consume alcohol have a greater tendency to use other drugs.[28] However, it is not known if this relationship varies among racial/ethnic groups.

NIDA's National Household Survey on Drug Abuse is frequently used as a source for estimates of rates of illicit drug use by race/ethnicity, educational attainment, and other characteristics. Table 3.5.2 presents the percent of all adolescents ages 12 to 17 and young adults ages 18 to 25 surveyed in 1988 who had ever used specified drugs, who had used them during the past year, and durig the past month.

The NIDA survey reported that White adolescents and White young adults were more likely to have used drugs in the past year and ever ("lifetime use"), compared to Black Americans in the same age groups, and that their rates were similar to those of Hispanic Americans. For example, 26% of White adolescents, 18.7% of Black adolescents and 24.3% of Hispanic adolescents had ever used drugs. For young adults, 62.5% of White youth surveyed had tried illicit drugs, compared to 47% and 47.6% of all Black and Hispanic young adults, respectively. The category of "ever-used" drugs is an indication of experimentation and is always much higher than the other categories, "used in past year" and "used in past month."

Figure 3.5.3 shows comparative use for the past year and past month, for White, Black and Hispanic males of all ages, based on the NIDA survey. This figure shows that, for all ages, Black and Hispanic illicit drug use was higher than of White males. However, as Figure 3.5.2 demonstrates, the type of drug used varies significantly by race and ethnicity: White respondents were much more likely to use hallucinogens, while Black and Hispanic respondents were much more likely to have used crack and heroin. The DAWN emergency room data shown in Table 3.5.1 supports this finding; for example, 57% of all cocaine mentions were for Black patients, 27% for White patients and 9% for Hispanic patients. Of all heroin/morphine mentions, 41% were among Black patients, 39% among White patients and 8% among Hispanic patients.

The 1988 National Household Survey found that for all measures of marijuana use -- lifetime, past year, past month -- White adolescent use was comparable to Hispanic use and higher than Black use. Dembo, on the other hand, found that White and Black adolescents have equal rates of marijuana use.[29] The Household Survey also found that Black respondents were four times as likely as White respondents to have ever used heroin.[30] Unfortunately, the survey does not disaggregate heroin use data by age or sex. It is important to note that Black adolescents who are addicted to heroin are four times as likely to die before they reach their mid-20s

than those who do not use heroin.[31]

One trend in these data, first seen in the 1985 National Household Survey on Drug Abuse[32], is the greater lifetime use of cocaine by Hispanic adolescents compared to White adolescents. Conversely, Black adolescents and young adults reported significantly lower lifetime use of cocaine and crack compared to either their White or Hispanic counterparts. In terms of recent use, the 1988 national survey reported that Hispanics ages 18 to 25 were again more likely to have used cocaine (including crack) in the past month compared to same-age White and Black young adults (see Table 3.5.2).

The number of users of prescription drugs is too small to permit accurate estimates (see Table 3.5.2). Nevertheless, from the limited data available, it appears that the use of stimulants in the past year and ever is considerably more likely among White adolescents and young adults, compared to their Black and Hispanic counterparts. Of the three groups, Black youth appear to have the lowest percentages of stimulant use. Although the data are even more limited in assessing tranquilizer use, it appears that those prescription drugs are also considerably more prevalent among young Whites.

The DAWN data cited earlier are also useful in balancing the underreporting of illicit drug use in household surveys. Of the 8,198 emergency room drug abuse episodes reported among males ages 10-19 in 1988, 55% were among White patients, 29% were among Black patients and 16% were among Hispanic patients.[33] Thus, minority populations are overrepresented in serious drug abuse episodes compared to their population proportion. Furthermore, according to DAWN data, minority populations may be disproportionately overrepresented in drug abuse deaths. In 1988, one-fourth of all drug abuse deaths among males ages 10 to 19 reported by the DAWN tracking system were among Black youth; Hispanic youth accounted for 16% of all such deaths.[34]

Data from the National Drug and Alcohol Treatment Unit Survey (NDATUS) also suggest that drug abuse/dependence is a serious problem among minority populations, especially Black youth. Black and Hispanic adolescents are more heavily represented among drug treatment program admissions than among alcohol treatment program admissions in specialized treatment facilities.[35] Evidence from DAWN and from NDATUS suggests that minority adolescents and young adults are more likely to be involved with more dangerous drugs (e.g., heroin and crack) that result in emergency room episodes or that require treatment. Black illicit drug users, and to a lesser extent Hispanic users, also seem more likely to use dangerous routes of cocaine administration (i.e., injection or freebasing) and to use several drugs in combination, with potentially fatal consequences.[36] Last, evidence suggests that Black adolescents experiment with drugs earlier than other ethnic groups.[37]

As the age-adjusted mortality rates from drug-related causes for Black and White males show (see Figure 3.5.1), the death rates for Black males now stand at 2.5 times that of Whites.[38] Unfortunately, drug-related causes of death are not available for the adolescent population. The category "drug-related causes" includes deaths from drug psychoses, dependent and independent drug use, accidental and deliberate poisoning, and suicide. It excludes homicide and other causes indirectly related to drug use. Black age-adjusted death rates from drug-related causes doubled from 1979 to 1987 (3.7 to 7.4 per 100,000), while rates for Whites remained relatively stable within the same time period (3.1 to 3.4 per 100,000).[39]

National data on the extent of illicit drug use among Native American and Asian American adolescents are not available.[40] Data from a 1980-81 survey of Native American high school seniors, when compared with NIDA's 1981 Annual Survey of American High School Seniors, showed higher lifetime prevalence rates of drug abuse among Native Americans for 10 of the 12 substance categories studied.[41] Lifetime prevalence differences were particularly high for marijuana and inhalants. Another study[42] found that more than one-third of Native American adolescents in grades 7 through 12 used marijuana and alcohol regularly, compared with only 5% for regular users among non-Indians.

With respect to illicit drug use among Asian American adolescents, a study of San Diego County 10th and 12th grade students conducted in 1985 found that Asian students reported low regular use rates for all drugs, compared to Hispanic, White, and Black students.[43] The study also indicated that Asian American adolescents had the lowest ever use rates in all drug categories. The results were surprising to the authors of the study, who had expected a higher percentage of substance experimentation given that a large portion of Asians in their study were new immigrants or first generation Americans who inhabited economically poor neighborhoods. The authors concluded that, "Assuming that the current peer-influence models are correct in explaining substance use as a peer driven phenomena, it is clear that Asian youth do not receive the same peer reinforcement for substance use as adolescents of other ethnic backgrounds or are perhaps more motivated to resist such pressure."[44]

Several studies have indicated that inhalant abuse is a significant problem for the adolescent Mexican American population. In a comprehensive report on drug use in the United States and along the United States-Mexico border, Adams notes that studies on Hispanic adolescents, especially those living in small ethnic enclaves, have indicated a strong propensity to abuse inhalants.[45] For instance, one study in 1979 indicated that Mexican American adolescents were at least 14 times as likely to be abusing inhalants as their Anglo counterparts in a national sample.[46]

Another pilot study conducted among 8th and 12th-graders in three small southwestern towns found a relatively high prevalence of inhalants.[47] The study also reported that the use of inhalants among high school seniors was lower than among eighth-graders, indicating the severity of drug use among younger Mexican American adolescents. Given the high dropout rate among Hispanic adolescents nationwide, the incidence of inhalant abuse is probably more serious than the studies indicate. Finally, Adams found that in Texas, Hispanics accounted for 57% of all heroin admissions and 88% of all inhalant admissions to drug rehabilitation centers.

3.5.3.1 Differences in Drug Abuse by Socioeconomic Status

National data which could be used to determine whether or not there are socioeconomic differences in adolescent drug abuse are lacking. In fact, only the National Survey of High School Seniors provides useful data, and it is minimal.

The use of illicit drugs by American high school seniors differs by socioeconomic status, as measured by the rate of use for seniors expecting to attend college versus those who are not. In every year between 1976 and 1987, those planning to attend college were reportedly less likely to use illicit drugs in the past year than those not planning to attend college.[48] The difference would be even larger if high school dropouts were included in the latter group. The difference in heavy use of marijuana by students not planning to attend college is especially large when compared with those planning to attend. When heavy use is defined as the percent reporting daily use in the previous 30 days, the 1987 seniors not planning college were more than twice as likely to report heavy use of marijuana as others (5.2% vs. 2.0%).[49] This difference appears to persist into early adulthood. When college students were compared with high school graduates of the same age, the percentages were 2.3% vs. 4.6%. Any use of cocaine within the past thirty days also differed strongly among the 1987 seniors with and without college plans: 3.6% vs. 5.3%, respectively.[50]

At the other end of the educational spectrum, a group of Mexican American and White adolescents who had dropped out of school between grades 6 and 12 was compared with a control group and an academically at-risk group.[51] The dropouts were found to have the highest rates of alcohol and drug abuse, followed by the at-risk students. Among the dropouts, 75% of Mexican American males and 90% of White males had tried marijuana. More than one-third of the dropouts had tried cocaine. The rate of cigarette smoking among dropouts was also significantly greater than the rate for the control group. Other results from the same study indicated that dropouts are more likely to be both victims and perpetrators of violence compared with those who remain in school. Estimates of dropout rates among Mexican American youth run as high as 45% in some locations.[52] In light of that study and of others that

have shown higher rates of drug use among dropouts,[53] prevention programs are needed to reduce dropping out and to improve the situation for those youth who do drop out.

Table 3.5.1

Percent Distribution of Drug Mentions in Emergency Rooms Reporting to DAWN, by Race/Ethnicity, According to Selected Drugs: 1988

Emergency Room Drug Abuse Related Episodes

	White	Black	Hispanic	Other	Unknow	Total
Alcohol-in Combination	44.5	37.2	9.2	0.9	8.2	100%
Cocaine	26.8	56.8	8.8	0.4	7.3	100%
Heroin/Morphine	39.0	40.7	13.1	0.6	6.7	100%
Marijuana/ Hashish	40.4	43.7	8.1	0.8	6.9	100%

Source: Department of Health and Human Services. Data From the Drug Abuse Warning Network. Annual Data, 1988. Series I, No. 8 Rockville: National Institute on Drug Abuse; 1989, Table 2.11, p. 35

Table 3.5.2

Percent Surveyed Reporting Drug Use, By Race: U.S. Civilian Non-Institutionalized Population, 1988

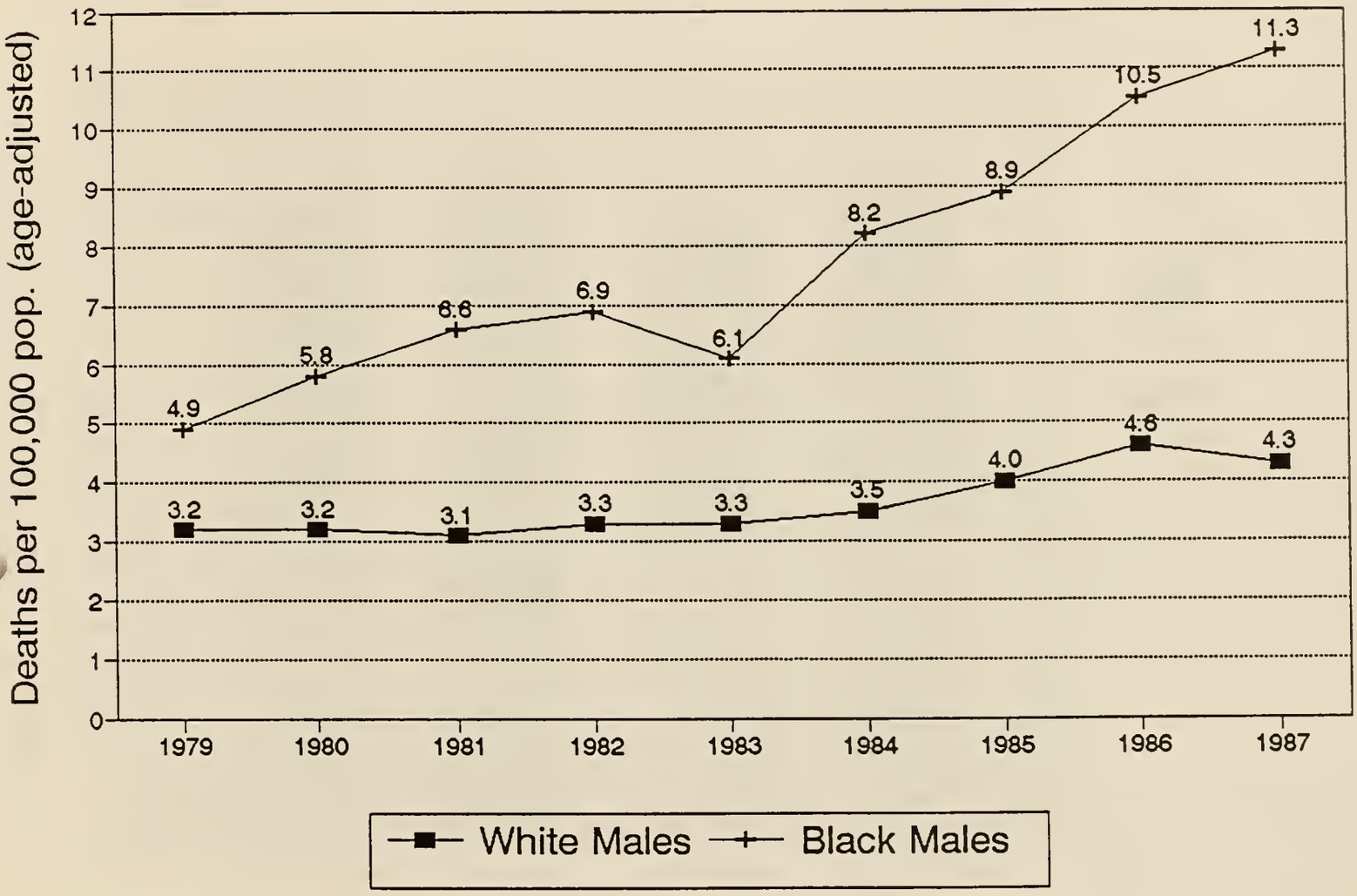
Drug	White		Black		Hispanic	
	12-17 yrs	18-25 yrs	12-17 yrs	18-25 yrs	12-17 yrs	18-25 yrs
			Used Past Month			
Marijuana	6.8	15.7	4.4	15.0	5.2	13.8
Cocaine (incl. Crack)	1.3	4.2	*	4.3	1.3	6.7
Crack	*	*	*	*	*	*
Inhalants	2.4	2.2	*	*	1.4	*
Hallucinogens	1.1	2.4	*	*	.5	*
Stimulants	1.5	2.6	*	*	.6	2.5
Tranquilizers	.3	1.2	*	*	*	*
Any	10.0	18.0	6.2	16.9	7.3	16.8
			Used Past Year			
Marijuana	13.0	29.2	9.1	23.5	12.8	22.1
Cocaine (incl. Crack)	3.2	12.6	1.4	8.1	3.6	12.6
Crack	.7	1.7	*	*	.9	3.5
Inhalants	4.7	5.2	1.6	*	2.4	1.5
Hallucinogens	3.6	6.5	*	*	1.7	5.1
Stimulants	3.4	6.8	.8	3.5	1.4	5.7
Tranquilizers	1.9	5.5	.6	*	*	3.8
Any	17.8	33.1	12.1	25.9	16.3	28.7
			Ever Used			
Marijuana	18.2	60.4	13.5	45.3	16.9	42.0
Cocaine (incl. Crack)	3.6	21.2	2.1	10.4	4.6	18.7
Crack	.9	3.3	.9	2.8	1.3	5.4
Inhalants	9.9	14.7	4.5	3.3	7.2	7.3
Hallucinogens	4.3	16.2	*	3.9	3.3	8.2
Stimulants	5.2	12.9	.8	3.9	2.0	8.5
Tranquilizers	2.5	9.4	.6	*	1.2	4.4
Any	26.0	62.5	18.7	47.0	24.3	47.6

*Low precisions; no estimates reported.

Source: National Institute on Drug Abuse. National Household Survey on Drug Abuse: Population Estimates 1988. DHHS Publication No. (ADM) 89-1636, 1989

Figure 3.5.1

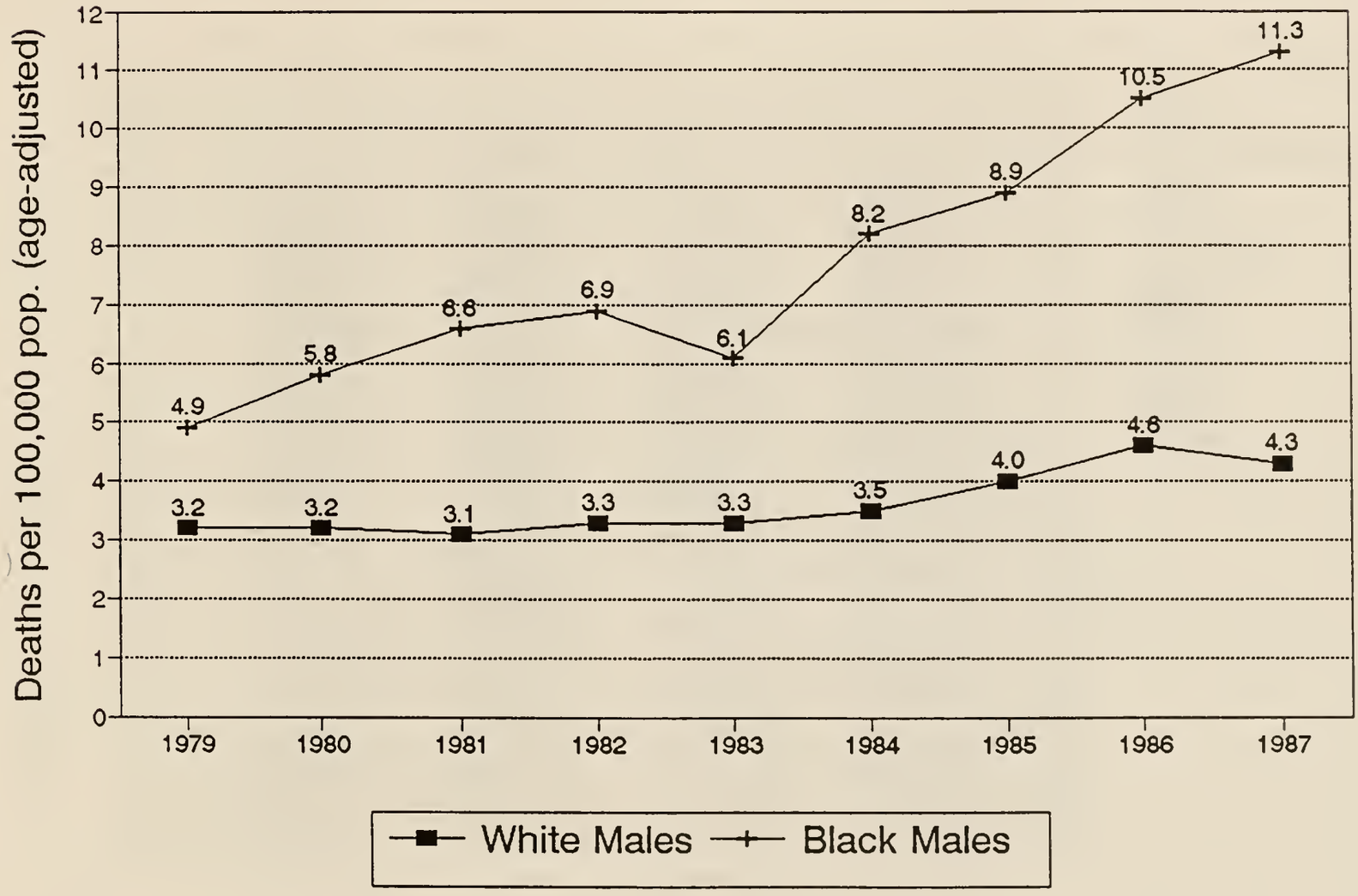
Death Rates for Drug-related Causes for Black and White U.S. Males, 1979-1987



Source: National Center for Health Statistics. Advance Report of Final Mortality Statistics, 1987, Monthly Vital Statistics Reports, Vol. 38,No. 5, Supplement, Sep 30, 1989, Table 26, p. 44

Figure 3.5.1

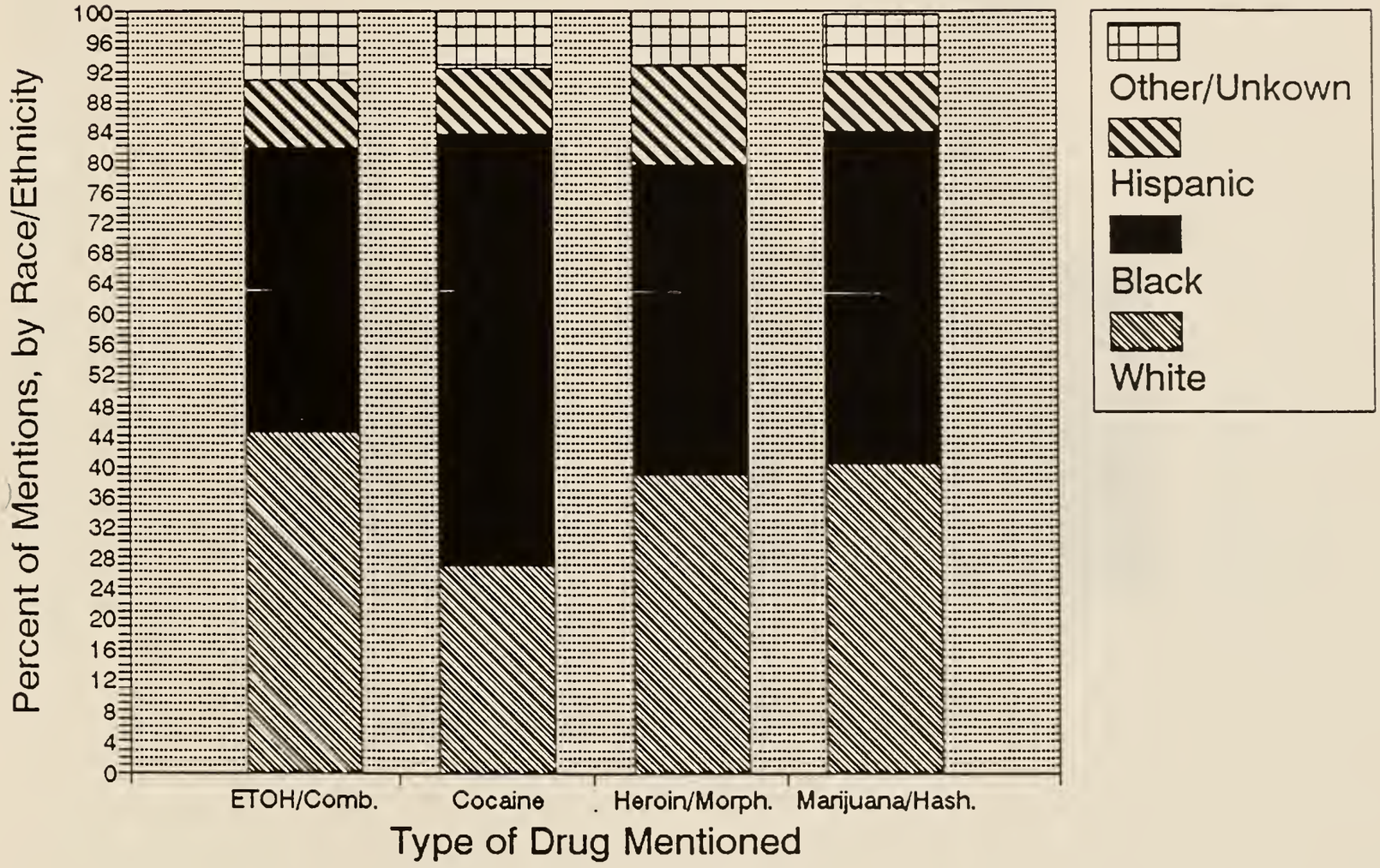
Death Rates for Drug-related Causes for Black and White U.S. Males, 1979-1987



Source: National Center for Health Statistics. Advance Report of Final Mortality Statistics, 1987, Monthly Vital Statistics Reports, Vol. 38,No. 5, Supplement, Sep 30, 1989, Table 26, p. 44

Figure 3.5.2

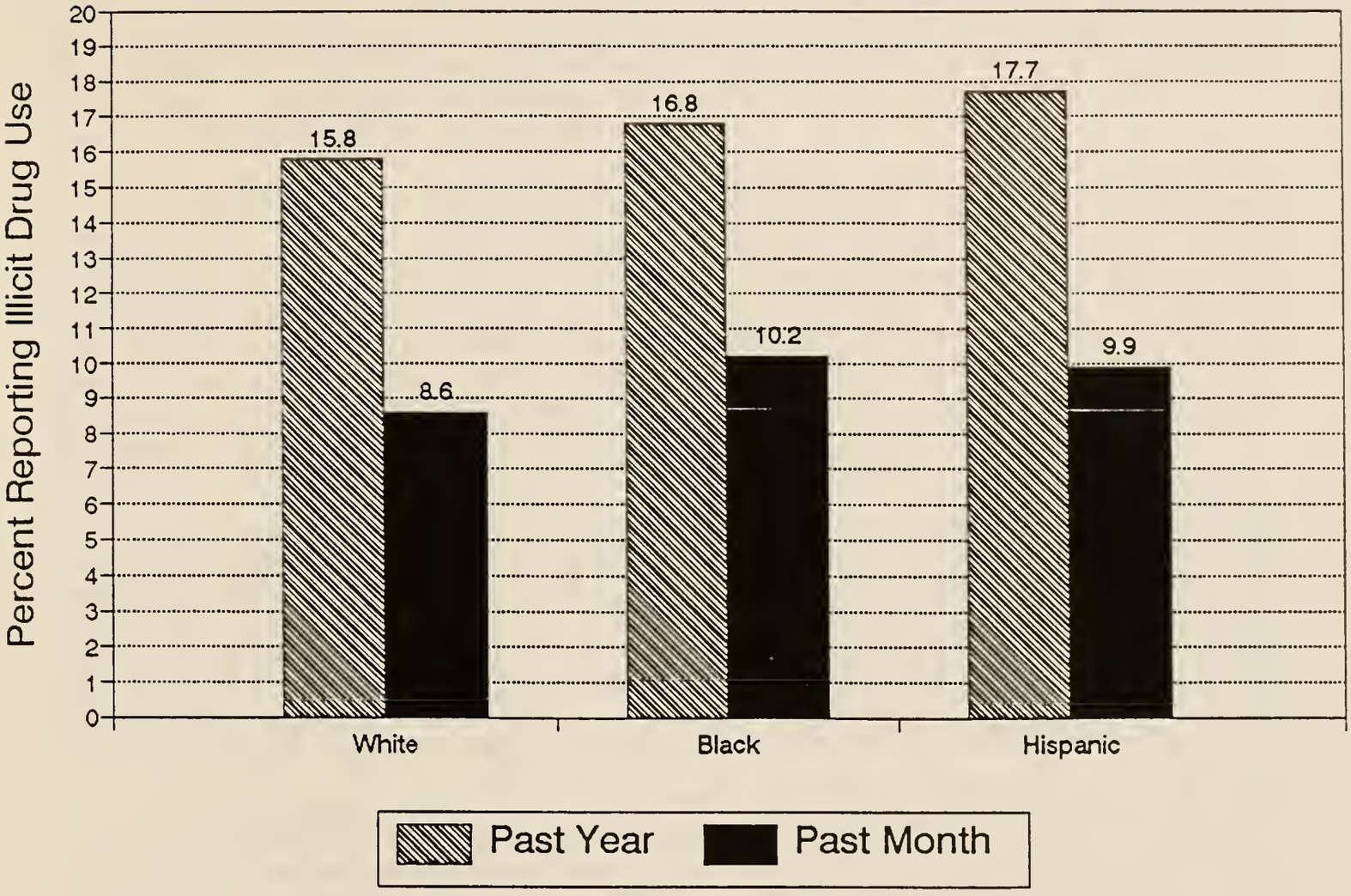
Percent Distribution of Drug Mentions for Selected Drugs, by Race/Ethnicity, 1988



Source: Prepared by Policy Research Incorporated based on data included in Table 3.5.1

Figure 3.5.3

Reported Illicit Drug Use by Males in Past Year and Past Month, by Race: 1988



Source: Prepared by Policy Research Incorporated based on data compiled and abstracted from: National Institute on Drug Abuse. National Household Survey on Drug Abuse: Population Estimates 1988. Department of Health and Human Services Pub. No. (ADM)89-1636, Tables 2B, 2C and 2D.

3.6 INJURIES

3.6.1 Overview

Injuries are a leading cause of morbidity and mortality among adolescents. The leading causes of accidental death and injury include: motor vehicle injuries, drownings, poisonings, firearms, burns and falls.[1] Injuries among adolescents differ by age, sex, socioeconomic status, and race and ethnicity.[2] Most injuries to adolescents occur where they spend most of their time, i.e., school and home. Serious injuries are also very likely to occur in suicide and homicide attempts.

As has been documented in earlier sections, the most significant factors contributing to increasing rates of death and disability among young minority males from intentional and unintentional injuries are poverty, family breakdown, racism and community disorganization. Other influences such as community attitudes towards violence, the mass media's glamorization of drugs and violence, and the easy accessibility of weapons exacerbate the effects of the impoverished environments of the inner-cities to produce unprecedented levels of interpersonal violence and self-destructive behaviors among minority adolescents.[3]

This section examines unintentional injuries, (more commonly called accidents) as well as intentional injuries among adolescent minority males. In particular, differences in mortality rates from unintentional injuries, suicides, and homicides between minority and White adolescents are reviewed. A shortcoming of existing injury-related data is the scarcity of reliable information about non-fatal injury incidence. Another problem is the dearth of unintentional injury data of any sort concerning Hispanics.

Injury types and rates differ by racial and ethnic group; rates of serious injury are highest among White adolescents in large part because of the high proportion of motor vehicle injuries suffered by this group. Motor vehicle injuries aside, the proportion of injuries suffered at home and, especially, at school are significantly higher for Black adolescents compared to White adolescents. These morbidity statistics are also reflected in the corresponding mortality statistics. Fatalities from injuries other than motor vehicle injuries are higher among young Black males compared to young White males. Finally, this section examines the specific risk factors associated with suicide and homicide among minority adolescents.

3.6.2 Unintentional Injuries

Unintentional injuries, the leading cause of death among adolescents, accounted for approximately 15.2 million non-fatal injuries among this group in 1980.[4] Table 3.6.1 presents injuries to adolescents ages 12 to 17 years that were severe enough to

restrict activity for at least one day or to require medical attention. With one exception (injuries occurring at home) Black adolescents appear to be at similar or lower risk compared to Whites. Their overall risk of injury is 35% lower than that of Whites'.

As Table 3.6.1 shows, the most common place for an adolescent to be injured is at school. Black adolescents are somewhat less likely to be injured at school than Whites (113.0 serious injuries per 1,000 Black youths age 12 to 17, compared to 129.6 per 1,000 for their White counterparts), less likely to be injured on the street (25.8 vs. 41.9), and considerably less likely to be injured in other locations (25.0 vs. 131.8). They are somewhat more likely to be injured at home (79.3 vs. 71.2).

These statistics may well underestimate the risk to Black youth. Injuries presented in the table are those causing activity restrictions or medical attention. Black youths' circumstances may not as easily allow for restrictions on activity when needed, as when a parent would be required to leave work to supervise a child at home. Moreover, families of Black youths as a group are less able to afford needed medical care.

In comparing rates of injury by place of injury, it should be recognized that the data do not take into account possible differences in exposure. In the case of school injury risk, to the extent that Black adolescents as a group spend less time at school--due to higher dropout rates, truancy, and other reasons--their injury rates at school would be underestimated by these data. Studies have shown that schools tend to harbor hazards.[5] Older, dilapidated schools found in some inner-city minority neighborhoods are more hazardous than up-to-date and better-maintained ones. Differences in the amount of violence occurring in schools may also make for higher-hazard school environments for Black students as a group.

Another possible exposure difference is in the motor vehicle category. The category motor vehicle fatalities includes motor vehicle collisions with other motor vehicles such as motorcycles and trains, with fixed objects, and with pedestrians and bicyclists. White adolescents have a significantly higher overall rate of motor vehicle injuries than Black adolescents in the same age group; this may be due to more access to motor vehicles among Whites.[6] If Black adolescents had the same motor-vehicle-related injury rate as their White counterparts, their overall injury rate would be 7% higher than the White rate, and not 35% lower.

Mortality statistics illustrate the racial difference in motor vehicle injuries. Since 1970, motor vehicle injuries among White youth ages 15 to 24 have remained proportionately higher than among Black youth of the same age (Figure 3.6.2). For young White males age 15 to 24, motor vehicle accidents alone accounted for 43% of

all deaths in 1987 (see Section 3.2). Whitman et al. have found that while motor vehicle accidents are the leading cause of head injuries among suburban White male teens, gunshot wounds are among the leading causes of head injuries among urban Black male teens.[7]

In the pedestrian category, Black youth are at considerably higher risk than are White youth, with the exception of Black youth age 15 to 19, who have a one-third lower risk.[8] For all other age groups in the Black population, including the other adolescent and young adult age groups, the risk is higher, and the overall population-wide risk difference is 60% higher for Black than for White youth. The reasons for the difference are not understood, but one hypothesis relates to exposure differences: fewer Black youth may own and drive cars than do White youth.

For unintentional injury deaths from other causes, as indicated in Figure 3.6.1, young adolescent Black males tend to have higher cause-specific death rates than their White counterparts. This is particularly true for Black males ages 10 to 14, who for example, are four times as likely to drown and twice as likely to die from burns than White males of the same age. Figure 3.6.1 indicates no significant racial difference in death rates from burns for males ages 15 to 19. But a local-area study by MacKay et al. found racial minority males had an excess risk of death from house fires compared to others.[9] In this study, conducted in five Massachusetts communities, Black and Native American males age 15 to 19 had the highest rate of house-fire-related deaths. Other data analyses have shown that the risk of death from house fires is particularly high in the Black population.[10]

According to the statistics in Figure 3.6.1, the Black/White difference in the injury death rates, excluding motor vehicle accidents, is less after age 14. Drownings, however, continue to disproportionately kill Black youth at ages 15 to 19 and 20 to 24. The literature offers no explanation for this. Possible explanations for the all-age Black excess include, greater exposure to hazardous or unsupervised swimming areas, lack of opportunities to take swimming lessons, and inability to take appropriate precautions for other reasons. It is also possible that some drowning deaths that were intentionally caused, were not discovered and coded as homicides, on the death certificate.

According to the Injury Fact Book,[11] Asian American adolescents experience the lowest rates of unintentional injury deaths -- approximately half the rates of White adolescents. Suicide and homicide rates (discussed below) among Asian American adolescents are also lower than among Whites. However, there may be wide variation in injury deaths among Asian American subgroups.

3.6.3 Intentional Injuries

3.6.3.1 Suicide

Suicide is more common among White youth than among minority youth. The Black/White mortality rate ratio for male adolescents and young adults age 15 to 24 in 1987 was 1.8 for suicide (see Section 3.2). Nevertheless, the suicide rate among Black youth has increased significantly since 1960. Section 3.2 indicated that the suicide rate among Black adolescent and young adult males more than doubled between 1960 and 1970, increased another 17% in the 1970s, and has leveled off at approximately 12 per 100,000 population since then. While suicide rates among Black youth are still lower than among Whites of the same age, it has been suggested that the figures would be much higher if causes of death among Black youth were reported as reliably as causes of death among White youth.[12] For example, if suspected cases of suicide by single-car accidents, deliberate drug overdoses, victim-precipitated homicides, and other violent accidents were included in the statistics, the Black suicide rates would be significantly higher than those now reported.[13] Research is now focusing on one aspect of the possible misclassification of deaths -- the extent to which apparent homicides were suicidally precipitated by their young Black victims. This research is examining the circumstances of these apparent homicides.[14]

Several explanations have been offered for the rise of suicide among Black youth. In an article published in 1986, Smith and Carter briefly summarized causes that have been advanced. These include:[15]

> an increased number of female-headed families, accompanied by disintegration of the black family and its extended family network;
>
> more physical abuse of Black children by their parents, resulting from economic and social stresses;
>
> higher poverty rates;
>
> growing alienation of Black adolescents from the larger society, partly caused by social changes such as desegregation;
>
> frustrations caused by shortfalls in progress since the social movements of the 1960s;
>
> the gradual erosion of respect for traditional Black institutions; and
>
> too few strong Black role models in school and elsewhere.

According to Smith and Carter, to these sociocultural explanatory factors can be added health and circumstantial factors, such as ongoing illness in the families, parental absence, family histories of mental illness, and the presence of firearms or medications in the home.[16] There are numerous studies that indicate a relationship between suicide and minority status, assimilation, and pressures arising from economic deprivation.[17]

Compared to the dimensions of the problem among Black youth, suicide is more serious among Hispanic youth, based on the limited data available. The most current study published[18] on Hispanic adolescent suicide focused on five southwestern states where nearly two-thirds of all Hispanics in the United States reside. Data were obtained on all suicides among Hispanics and Anglos (White non-Hispanics) from 1976 to 1980. The study revealed that Hispanic and Anglo suicide rates among adolescent and young adult males were similar from 1976 to 1980. Since young White males are considered to have very high suicide rates, it is disturbing that young Hispanic males appear to have comparable rates.

Another study on suicides among adolescents age 13 to 19, in Dade County, Florida,[19] found that an unexpectedly high proportion of the suicides occurring recently were among Puerto Rican teenagers. In 1988 Hispanics accounted for 46% of the population of Dade County, and Puerto Ricans accounted for 6% of the greater Miami population. But during the 18 months ending June 1989, 61% of the 23 teenage suicides in Dade County were Hispanic, and 36% were of Puerto Rican origin. The proportion of suicides that were Hispanic was even higher among 13- and 14-year-olds. As with most other reports of teen suicides, the great majority of the Hispanic suicides, 80%, were male. The authors of the Dade County study pointed out that "a sizeable proportion of the Latins in Miami are relatively recent immigrants still dealing with multiple migration and acculturation problems and economic marginality."[20] On this basis, higher-than-average numbers of suicides are, perhaps, predictable, although the authors admitted that they had not expected results of such proportions.

Data and research on suicide among Native American teenagers point to a significant and long-standing problem. The average suicide rate from 1984 to 1986 among Native American males age 15 to 24 was 40.9/100,000 -- 1.9 times the rate for the nation as a whole, 1.7 times the White male rate in 1986, and 3.6 times the Black male rate in 1986. Suicide figures for 1980-1982 among Native Americans ages 10 to 14 indicate even more disparity between younger Indian and non-Indian suicide rates.[21] Suicide is reported as causing 15% of all Native American deaths among young males and females age 15 to 24.[22] Suicide prevention has become a critical issue in many tribes.

It has been noted, however, that not all Native American tribes have alarming suicide statistics.[23] The suicide rates among

the Navajos are close to the national average, and on some tribal reservations, the rates are substantially lower.[24] [25] By contrast, suicide rates among the Apache tribes in the Southwest are more than twice the national average.[26] A study of tribal differences in New Mexico found that one fundamental factor appears to be social organization of the tribe. More tightly integrated, usually traditional, tribes tend to have lower rates, while more loosely integrated tribes are associated with higher rates.[27] The more fluid, less traditional social structures often lead to disrupted families, alcoholism, child neglect, and other chaotic situations for adolescents.[28] In these circumstances, which in some cases followed displacement from traditional lands and livelihoods, "adults appear unable to unite tradition and acculturation in any meaningful way."[29]

Increases in suicides between 1957-79 among all New Mexico tribes was attributed to rapid social change.[30] Specifically, the groups' social contact with mainstream U.S. society increased, apparently causing more acculturation stress, anxiety, and disruption. These problems may have led to higher suicide rates. Several studies have suggested that Native American adolescent suicides were more likely than control group suicides to have experienced personal chronic stressors, such as multiple caretakers while growing up; multiple losses caused by divorce, suicide, or desertion; arrests; parental alcoholism; and boarding school enrollment.[31] [32] These micro-level studies agree with correlational studies showing that tribes with high adolescent suicide rates also have high rates of alcoholism, drug and inhalant abuse, child abuse, increased numbers of auto accidents and homicides related to alcohol use, and high unemployment.[33] As noted above, these problems have been attributed to assimilation and the deterioration of traditional social structures and lifestyles.[34]

Particularly high adolescent suicide rates are seen among Native American adoptees raised in non-Indian families.[35] Approximately 50,000 Native American children now live with adoptive White families, but many are not assimilated into either Anglo or Native American communities.[36] As a result they find themselves isolated, victimized by discrimination, and without a sense of cultural identity.[37] A result of this social alienation may be the excess suicide rates found in this population. Notably, certain risk factors for suicide are more often found in low-income and minority households. These include a high incidence of violence, more unwanted pregnancies, fewer social supports, greater incidence of running away from home, and more chaotic and stressful environments.[38]

3.6.3.2 Homicide

As has been described in Section 3.2, Mortality, the homicide rate for young Black men age 15 to 24 is significantly higher than that of other adolescent males. The most recent data, for 1987,

indicate that the homicide rate among this group is 7.6 times as high as that for young White males (see Section 3.2). Current estimates are that a young Black male has a five percent chance of being killed during his lifetime.[39] [40] According to a special report on Black and minority health prepared by the Department of Health and Human Services, "Homicide accounts for more excess mortality among Black Americans under age 45 than any other cause of death."[41] In 1988, 49% of all murder victims between 10 to 14 were Black and 59% of all murder victims in the age group 15 to 19 were Black.[42]

Cross-national comparisons in 1985 show that homicide in males ages 15 to 19 is five times more common in the United States than in Canada and Australia, and 20 times more common than in Europe.[43] For American Black males of this age, the homicide rate was 17 to 155 times higher than that for same-age males of all races in eight other industrialized nations.[44] In 1986, the homicide rate for Black males age 15 to 19 in the United States was 51.5/100,000 -- 18 times higher than the next highest all-races rate of 2.9/100,000 in Australia.[45]

With respect to homicide among Hispanic adolescents, the rate for 15 to 24 year old Hispanic males in the five southwestern states was significantly higher in 1976-80 than the comparable Anglo rate.[46] For Hispanics ages 20 to 24, the homicide rate was four times the Anglo rate and approaches the rate for Black males nationally. Although these data are at least a decade old, they suggest, according to the analysts, "a strong need to pay attention to young Hispanic males as well as young Black males" in planning homicide intervention strategies.[47]

The homicide rate for adolescent male Native Americans ages 15 to 24 in 1984-86, at 32.2/100,000, was nearly three times the 1985 rate among Whites (see Section 3.2). This rate comparison means that young Native Americans as well as young Black Americans need to be targeted for intervention programs. Unfortunately, little research on the subject of adolescent homicide among Native Americans is available.

Most homicides in the United States involve relatives and acquaintances and are committed against persons of the same race as the offender.[48] A study in New York State in 1987[49] explored the circumstances of adolescent homicides. It was found that over 80% of adolescent homicide victims were killed by someone they knew, either an acquaintance or a family member. In addition, the study indicated that 38% of all homicide victims 19 years or younger were killed by someone in the same age group. In total, 11% of all of those who committed homicide in 1987 in New York were under 20 years of age. Black adolescents are also significantly more likely to be killed in a confrontation with the police than are White adolescents.[50] National data from 1979 indicate that more than 65% of homicide deaths among Black males ages 15 to 24 were not related to criminal events.[51] As these data and the New York State

statistics suggest, in many cases it is the outcome of the conflict that determines who is the assailant and who is the victim.

Table 3.6.1

Injuries to Adolescents Ages 12-17 Years: United States, 1985-1986

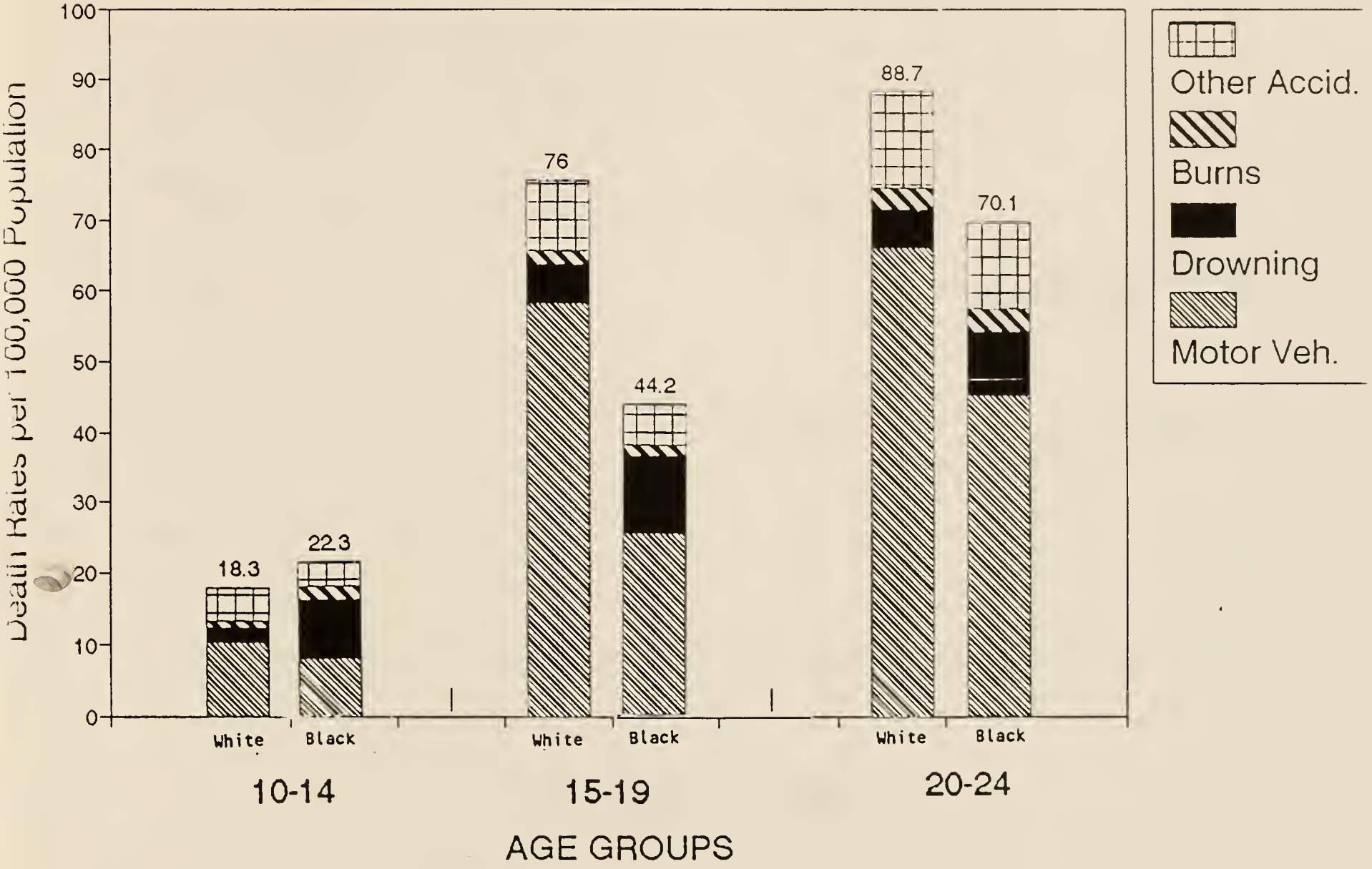
	Total	Race		Sex	
		White	Black	Male	Female
		Episodes Per 1,000 Persons			
Rates	369.3	374.5	243.1	468.7	266.7
		Rates Per 1,000 Persons			
School		129.6	113.0		
Home		71.2	79.3		
Street		41.9	25.8		
Other & DK		131.8	25.0		
Motor Vehicle		170.0	13.1		
		Episodes in Thousands			
Episodes	8,101	6,733	960	5,210	2,890
		Percent Distribution			
Total	100.0	100.0	100.0	100.0	100.0
School	37.0	34.6	46.5	37.5	36.1
Home	21.0	19.0	32.6	20.5	22.0
Street	10.5	11.2	10.6	10.3	10.9
Other & DK	31.5	35.2	10.3	31.7	31.0
Motor Vehicle	5.1	45.4	5.4	4.4	6.4

Note: Only episodes severe enough to restrict activity for a day or to receive medical attention are included.

Source: Helen M. Wallace, George Ryan, Jr., Allan C. Oglesby, "Maternal and Child Health Practices," Third Edition, Third Party Publishing Co., 1988, p. 525
Black and White rates per 1,000 person compiled by Policy Research Incorporated

Figure 3.6.1

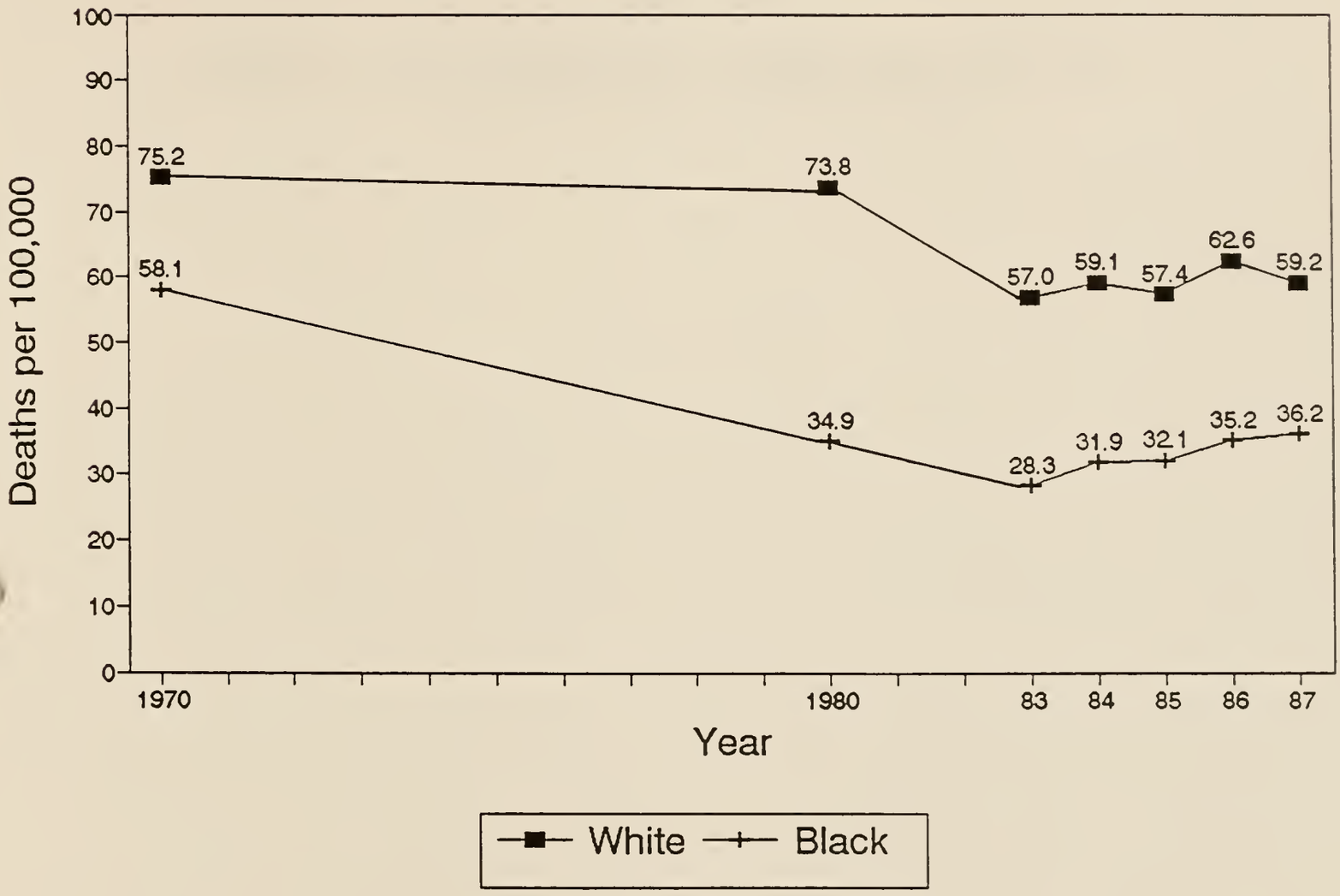
Deaths Rates (per 100,000) for Unintentional Injuries for Male Adolescents, By Race: United States, 1986



Source: National Center for Health Statistics. Vital Statistics of the United States, 1986, Vol. II, Mortality, Part A. DHHS Pub. No. 87-1122. PHS. Washington, DC: U.S. Government Printing Office; 1989

Figure 3.6.2

Motor Vehicle Deaths for Males 15-24, By Race: United States, 1970-1987



Source: Figure prepared by Policy Research Incorporated, based on data from: National Center for Health Statistics. Vital Statistics of the United States, 1987, Vol. II: Mortality, Part A. PHS. Washington, DC: U.S. Government Printing Office

PART FOUR:

FINANCING AND UTILIZATION OF HEALTH CARE SERVICES FOR ADOLESCENT MINORITY MALES

4.1 OVERVIEW TO PART FOUR

This report concludes with Section 4., which addresses financing and utilization of health care services among minority and low-income adolescents. In Section 4.1, the insurance status of White, Black and Hispanic adolescents is analyzed; although insurance data regarding Native Americans and Asian Americans are not available. For low-income families, the role of Medicaid in providing access to health care services is discussed. Section 4.2 reviews the health care utilization patterns of Black, White, Hispanic and Native American adolescents, as well as those of low-income and homeless adolescents. Lastly, the role of school-based clinics in health promotion and disease prevention among adolescent minority males is discussed.

The majority of studies on access to health care have aggregated children and adolescents into a single category. Because children and adolescents have different health care needs, health care access issues for the two age groups differ somewhat. This section cites studies that have age-disaggregated data by racial and ethnic groups. It should be noted that health care utilization patterns for young people are complex and are associated with a wide range of interrelated factors. Among the most significant factors are the socioeconomic status of the family, educational attainment of the parents, insurance coverage, family structure and health beliefs.

Poverty is related to a number of health states of adolescents,[1] for example, poor adolescents experience more episodes of chronic illness, more days of restricted activity and more school days lost to illness. Poverty also affects access to health care services, an intervening variable in these outcomes. In 1987, 12.4 million American children lived below the poverty level;[2] Black, Native American, and Hispanic youths are disproportionately represented in this group (see Section 2). Because insurance coverage is strongly related to access to health care, this section begins with a discussion of the health insurance status of minority adolescents. Results from a nationwide survey indicate that almost one-fifth of all Black adolescents and one-third of all Hispanic adolescents were uninsured in 1984. Furthermore, the most recent survey (the 1984 National Health Interview Survey) indicates that only 37% of all adolescents living in poverty had Medicaid coverage.

A separate analysis of health care utilization patterns of adolescents indicated that Black and Hispanic adolescents were less likely to visit a physician annually even though they were reported to be in poorer health compared to their White counterparts. Native American, low-income, and homeless adolescents are especially at risk for not obtaining necessary health services.

Affordable health services are important for Asian communities as well, especially the newly arrived Southeast Asian refugees who are at high risk for developing health and mental health problems.

Besides the financial barriers to health care service utilization, barriers imposed by physicians who are not adequately trained to deal with adolescent health and social problems are discussed. Finally, the role of school clinics as a source of health care and counseling for adolescents is presented. Although conclusive results concerning school-based pregnancy and substance abuse programs are still not available, the ability of these programs to attract minority adolescent males is encouraging.

4.2 FINANCING OF SERVICES FOR MINORITY ADOLESCENTS

In the United States, the majority of health services for acute and chronic illnesses is financed by a mixture of public and private insurance. Private insurance is almost exclusively employment-related and differs widely in terms of coverage. In contrast, public insurance almost universally covers the older population and the disabled, and covers some of the nation's poor. The importance of health insurance coverage in influencing the use of health services, particularly ambulatory services, among children and adolescents has been well documented.[3,4,5,6] However, because data on adolescents have not usually been disaggregated in national surveys, little has been known about the insurance status and characteristics of adolescents, especially minority adolescents. Recently, several new analyses have been published.

4.2.1 Health Insurance Coverage

A recent study by Newacheck and McManus, based on the 1984 National Health Interview Survey,[7] analyzed data for 15,181 children and adolescents ages 10 to 18. Results, shown in Table 4.1 and Figure 4.1, indicate that a disproportionate number of minority adolescents are not covered by private insurance but rather either have some form of public insurance or are uninsured. Specifically, Black adolescents were 63% more likely to be uninsured and more than four times as likely to be covered by public insurance compared to White adolescents. The disparity is even more dramatic for Hispanic adolescents. Nearly one-third of all Hispanic adolescents are uninsured. Hispanic adolescents are 2.7 times and 1.6 times as likely as their White and Black adolescent counterparts, respectively, to be uninsured. Of all adolescents in racial/ethnic groups, Hispanics are the least likely to have private or public health insurance coverage.

Family economic status strongly predicted the existence and type of insurance coverage for adolescents (Table 4.1). Thirty-one percent of all adolescents below the poverty level were uninsured, compared to only 9% of all adolescents above the poverty level. The high percentage of poor uninsured adolescents reflects the inadequate Medicaid coverage of poor children in the United States. Rates of noncoverage declined with income for adolescents with family incomes above $15,000 per year. In the lowest-income groups however, there was no decline with income; the very lowest income group (less than $5,000 per year) was less likely to be uninsured than the next-lowest ($5000 to $9,999). The six-percentage-point difference in noncoverage rates is almost entirely due to more-frequent public insurance for the lowest-income group (44% vs. 38%). The third-lowest income group ($10,000 to $14,999) was as likely to be uninsured as the very lowest (27%). Beginning with this income group, the source of coverage for the three-quarters or more with coverage was overwhelmingly private,

whereas for the two lowest income groups, the source of coverage was somewhat more likely to be public than private.

Many sociodemographic variables such as race and ethnicity, are highly correlated with education and income. However, Newacheck and McManus found that, even after controlling for the effects of family income, Hispanic adolescents continued to be much less likely to have any health insurance coverage, possibly reflecting barriers posed by language, sociocultural factors, residency requirements, and immigration status.[8]

Corroborating the observed relationship between income and insurance coverage, when respondents were asked why they had no insurance, the leading reasons cited were financial. Other sociodemographic characteristics associated with lack of health care insurance among adolescents include: family heads with less than a high school education, living with other relatives or with one parent, living in a central city or rural environment, and living in the South or West.[9] A final finding of the study was that adolescents reported to be in fair or poor health were more than twice as likely to be uninsured compared with adolescents reported to be in excellent health.[10]

In a companion study, also based on the 1984 NHIS survey, the sociodemographic characteristics of young adults were analyzed by type of health insurance coverage.[11] (See Table 4.2) Figure 4-1, summarizing results of these studies, shows that young adults ages 19 to 24 were more likely to be uninsured than adolescents ages 10 to 18. In fact, young adults are the population group at greatest risk of being uninsured, according to all national medical care expenditure surveys.[12] This is not surprising, because persons in this age group have recently entered adulthood and are no longer beneficiaries of their parents' private or public insurance, but may not have employment-related coverage of their own.

Marked racial and ethnic differences in insurance coverage among young adults are apparent in Table 4.2. Hispanic and Black young adults were 95% and 51% more likely, respectively, to be uninsured compared to White young adults. In contrast to adolescents, among whom gender differences in coverage are negligible (Table 4.1), such differences in coverage do exist among young adults (Table 4.2). Specifically, males ages 19 to 24 are 21% more likely to be uninsured compared to females of the same age. This is presumably because females in this age group with children may qualify for Medicaid or females may be covered by a spouse's insurance. Notably, more than half of all unemployed young adults were uninsured.

A recent paper from the Congressional Office of Technology Assessment reports that the proportion of adolescents without health insurance increased from 16.7% to 20.8% from 1979 to 1986.[13]

This increase in the number of uninsured is larger than the corresponding increase for the overall population under age 65. Among the factors contributing to the higher percentage of uninsured adolescents and young adults are the more stringent Aid to Families with Dependent Children (AFDC) eligibility requirements legislated in the early 1980s, the decrease in the number of families able to obtain employment-related health insurance, the increase in insurance costs which outpaced the growth in incomes, and the growth of employment industries that are less likely to offer health coverage.[14]

4.2.2 Public Financing Mechanisms

Since its enactment in 1965, Medicaid, a joint federal/state program in which the federal government matches state expenditures, has greatly expanded the federal government's role in financing health care for the poor.[15] Contrary to common belief, however, Medicaid is not a broad entitlement program that assures all poor persons access to health care services. Medicaid eligibility policies are very complex and are determined separately for each state. The Medicaid program varies widely across states although states must enroll individuals receiving cash assistance under the AFDC program and most older, blind, and disabled recipients of Supplemental Security Income (SSI). Under Medicaid, all states are required to cover, at a minimum, inpatient and outpatient hospital services, physician services, laboratory and x-ray services, family planning, screening and diagnostic services for children, home health care, and nursing home care.[16]

In fiscal year (FY) 1988, nearly 25 million Americans were covered by Medicaid: 16.6 million poor children (under age 18) and their parents, 3.5 million poor older persons, and 3.4 million disabled persons were eligible. In FY 1986 (the latest available data), about 27% of Medicaid beneficiaries were Black and 8% were Hispanic, although these groups represent 12% and less than 7% of the general population, respectively. Another 3% of beneficiaries were Native American, Asian, Alaskan Native or Pacific Islander, 8% were of unknown race and ethnicity, while the largest portion, 53%, were White.[17] Minority populations are more likely to be covered by Medicaid than Whites, reflecting a higher incidence of poverty among these groups.

Examining the distribution of Medicaid recipients by entitlement category (Figure 4.2) indicates that in FY 1988 nearly half of all Medicaid recipients were children in AFDC families (43.8%), approximately 14% were older persons, and 15.2% were blind and disabled. Although the young poor comprised the largest eligibility group, they accounted for only 12% of Medicaid expenditures in FY 1988. This is a reduction by one-third in the proportion of Medicaid expenditures spent on children and adolescents since 1972 (see Figure 4.3).

One service requirement of particular importance to children is that states provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to Medicaid eligible children up to age 21.[18] The EPSDT program was designed to assure the availability and accessibility of required health care resources and to help eligible children use them effectively. Under this program, States are not only required to finance services, but also to conduct outreach activities that link Medicaid-eligible children with health care providers. In FY 1987, 5,832,151 children ages 6 to 20 were eligible for the EPSDT program; the average number of screening examinations conducted, 798,606, was much lower.[19]

Research indicates that individuals and their families dropped from Medicaid, experience a deterioration in their access to health care services.[20] [21] [22] An analysis by Rosenbach[23] demonstrated that Medicaid coverage increases use of office-based physicians among low-income children. Children with Medicaid coverage were more likely than both privately insured (and often underinsured) and uninsured children to visit an office-based physician. Newacheck et al. found substantial differences in utilization rates when data on poor adolescents were disaggregated according to Medicaid coverage.[24] Those with Medicaid coverage used physician services at rates similar to non-poor adolescents, while those without Medicaid coverage had substantially lower utilization rates.

Although Medicaid was originally created to provide health care to poor families, it has increasingly become the primary financier of long-term care for persons 65 and over.[25] The Omnibus Budget Reconciliation Act of 1981 (OBRA) reinforced the shift favoring the older poor.[26] Among the most important provisions in the 1981 OBRA was a limitation on the amount of earned income that could be disregarded in determining AFDC eligibility. This affected the working poor's eligibility for Medicaid. The direct result of the 1981 OBRA was a decline in Medicaid coverage of the recipients of AFDC, i.e., the non-aged poor. Rowland at al.[27] reported that children and adolescents experienced the most significant loss of coverage, from 52.1% of all young AFDC enrollees to 45.4%.

Despite recent legislative changes that have appeared to broaden Medicaid eligibility, e.g., OBRA 1984, OBRA 1985, and the Deficit Reduction Act of 1984 (DEFRA), Medicaid's coverage of poor children and adolescents in particular is eroding. The increased mandated coverage of the non-AFDC families and children did not offset the decline in coverage caused by the failure of AFDC benefit levels or eligibility thresholds to keep up with inflation.[28] In other words, the earned income level which will permit Medicaid eligibility for AFDC families must be higher to make any significant impact in terms of increased coverage for the poor.

Figure 4.4 reveals the erosion of Medicaid's coverage of poor children ages 17 and under between 1979 and 1983. Figure 4.4 shows that, while a dramatic increase in the total number of poor children in the early 1980s occurred, the number of poor children covered under Medicaid slightly increased and then remained at the same level. Between 1983 and 1986, the total number of poor children decreased (from 13.4 million to 12.4 million, see Table 2.4.8), while the number covered by Medicaid remained the same. According to Current Population Survey (CPS) estimates, nearly one-half of all poor children were not covered by Medicaid in 1986.[29] Even fewer adolescents are covered by Medicaid. Results from the 1984 National Health Interview Survey indicate that only 37% of adolescents living in poverty had Medicaid coverage.[30] In other words, six out of 10 poor adolescents -- three million in 1984 -- were not covered by the Medicaid program. Since 1984, the Medicaid expansions have benefited only pregnant women and children. There is no reason to assume therefore, that the percentage of poor adolescents without Medicaid coverage has changed since that time.

4.3 UTILIZATION OF HEALTH CARE SERVICES

An analysis was made by the National Center for Health Statistics of data collected in the 1980 and 1981 National Ambulatory Medical Care Survey (NAMCS), which is a sample survey of office-based physicians.[31] The NAMCS survey was conducted again in 1985, but unfortunately many detailed results are not yet available. With the Medicaid cutbacks in the 1980s, a comparison between the two surveys would be expected to reveal a greater racial and ethnic disparity in health services utilization among adolescents in 1985 than in 1980-1981.

Adolescents ages 11 to 20 do not visit physicians (either alone or accompanied by a parent or guardian) as frequently as persons in other age groups.[32] Data from NAMCS collected in 1980 to 1981[33] indicate that although adolescents constituted 17% of the U.S. population in 1980, they accounted for only 11% of all visits. Their annual visit rate was 1.4 for age 11 to 14 and 1.8 for ages 15 to 20 (Table 4.3). This compares with 2.8 for persons of all other age groups in the United States in 1980-81. This relatively low utilization rate is not the result of lower incidence of illness in this group. In fact, adolescents have a higher incidence of acute conditions than older age groups.[34] The low rates of office visits may be related to the low severity of acute conditions among adolescents, together with relatively low prevalence of chronic disease. Another reason may be that many conditions, such as drug abuse and sexually transmitted diseases, remain untreated among adolescents. The leading reasons for office visits by adolescents ages 10 to 14 were cough, throat or ear problems.[35] Prenatal examination and acne were the most frequent reasons for visits among older adolescents.

Table 4.3 shows the average annual number of office visits for adolescents, disaggregated by age, race and gender. Among younger adolescents, ages 11 to 14, the annual office visit rates between males and females are comparable. From ages 15 to 20, and in all other older age groups, females are approximately 1.5 times as likely as males to make an office visit. There are also marked racial differences in the average annual visit rate of adolescents. Specifically, White adolescents ages 11 to 14, and ages 15 to 20, were 70% and 55% more likely, respectively, to visit a physician than were Black adolescents. Overall, White adolescents were approximately 1.6 times as likely as Black adolescents to make an annual office visit during 1980 to 1981. The racial disparity in average annual office visits is about three times as great among adolescents as among all other age groups (Table 4.3). Information concerning the major reasons for the visit, principal diagnosis, physician specialty, and duration of visit for different racial groups is not available; this might help to explain the different health care utilization patterns of Black and White adolescents.

More recent NCHS data also indicate that Black adolescents are less likely to visit a physician annually compared to adolescent Whites. About 71% of all White males ages 12 to 17 had at least one contact with a physician during 1985-1986 compared with 60% of all Black males of the same age.[36] Several regional studies have suggested that substantial barriers to health care service utilization exist for adolescents living in low income inner-city areas.[37] [38] [39] Ironically, these deprived areas are often in the vicinity of many hospitals.

According to the 1980-1981 NAMCS survey, Hispanic adolescents accounted for only 5% of all office visits (Table 4.4). These figures are supported by the results of the 1979 National Health Interview Survey (NHIS), a sample survey of households across the United States. The 1979 NHIS demonstrated that Hispanic children and adolescents were less likely to contact a physician compared with White Non-Hispanics and Black Non-Hispanics in the same age group even though Hispanic parents were most likely to report their children in poor or fair health.[40]

The most recent data available from the 1988 NHIS concur with these observations. Table 4.5 shows health care utilization of children and adolescents by selected characteristics. In 1988, Black children and adolescents ages 5 to 11, 12 to 14, and 15 to 17 had significantly fewer physician contacts than their White counterparts. Thirty-four percent and 32% of all Black adolescents ages 12 to 14 and 15 to 17, respectively, had not contacted a physician in the past year. This does not necessarily imply that Black adolescents are healthier than White adolescents since, excluding hospitalization for delivery, White and Black youth ages 15 to 17 had similar hospitalization rates in 1988.

Unfortunately, little is known about Native American adolescent utilization of health services. The mission of the Indian Health Service (IHS) is to provide access to a complete range of care.[41] However, no research has been conducted on the factors that affect Native American adolescents' utilization of health care services. A study of disadvantaged Native American and Mexican American adolescents ages 14 to 21 indicated that condescending physician attitudes, transportation problems and other nonfinancial factors were significant barriers to health care use.[42] It is possible that, because the IHS is often the major employer in small Native American communities, adolescents fear for their privacy and do not seek appropriate health care. Newly arrived Southeast Asian immigrants, another population at-risk for developing physical and mental heath problems,[43] do not have access to adequate health education programs which promote disease prevention and better nutrition practices.[44]

Income status has a dramatic effect on health care utilization among children and adolescents (see Table 4.5). Youth in families with incomes between the poverty level and twice the poverty level had the least number of annual physician contacts and were the most likely not to have seen a physician at all in 1988. Furthermore, data in Table 4.5 show that the percentage of youth with at least one hospitalization was inversely proportional to family income.

An analysis of health care utilization patterns of adolescents by income status was conducted by Newacheck using a sample of 22,792 adolescents ages 10 to 18 from the 1983 and 1984 National Health Interview Surveys.[45] After accounting for differences in health status, results indicated that adolescents from poor families were 35% more likely than those from non-poor families to have waited two or more years between physician contacts. In general, poor adolescents made 13% fewer physician contacts annually, compared to non-poor adolescents.

Since 1980, an increasing number of families with children, predominantly from racial minority populations, have entered the ranks of the homeless population.[46] Recent studies indicate that homeless adolescents do not obtain appropriate health services. To determine the health status and utilization patterns of homeless adolescents, a survey was performed of 82 homeless families living in emergency shelters in King County, Washington.[47] Seventy-five percent of children and adolescents belonged to racial minority populations: 43.7% Black; 8.2% Hispanic; 6.3% Native American; 0.6% Asian; and 14.6% mixed. More than one fourth were age 11 to 17. Homeless children used emergency rooms when seeking medical care at a rate two or three times higher than the overall U.S. population of the same age. The data in this study suggest that homeless children, overwhelmingly from minority families, are in poorer health and do not obtain necessary preventive care.

Another group of adolescents who are at particular risk for not receiving adequate health care are migrant and seasonal/farm workers and their families. The average annual income for these families, who constitute a major portion of the labor force in the American food industry, is well below the poverty level.[48] Since health care insurance is invariably beyond the reach of migrant family budgets, and employers of farm workers rarely provide health care benefits for their employees, these families are usually uninsured.[49] In some cases, these families lack U.S. citizenship or are in this country illegally, which complicates obtaining health care for their children.[50] Medicaid enrollment is also complicated by migration because aliens must meet eligibility requirements in each state to which they migrate, and only US citizens are eligible.

Because of their income and mobile lifestyle, migrant worker families often find that comprehensive adolescent health care is essentially not available. Migration not only interrupts continuity of care but it also contributes to a lack of knowledge about a community's health services and/or jeopardizes eligibility for these services by conflicting with residency requirements.[51] Other problems that delay or prevent access to health care for the children of migrant families include language barriers and differences in culture. Common problems of migrant workers include overcrowded living conditions and poor sanitation facilities.[52] Migrant adolescents are at increased risk for respiratory and ear infections, intestinal parasites, pesticide exposure, tuberculosis, poor nutrition, teenage pregnancy and accidents.[53] [54] Many migrant adolescents have never been screened for chronic disease or vision and hearing impairment.

A major obstacle to health care utilization among adolescents is limited physician training in adolescent health problems. Many physicians are ill-prepared to deal with such adolescent health problems as eating disorders, gender identity issues, school problems, chronic illness, drug abuse, and behavior and delinquency problems. For example, a national survey of primary health care physicians in 1985 revealed that at least 50% identified major deficiencies in their expertise in one or more of the areas listed above.[55]

4.3.2 School-Based Adolescent Health Clinics

Traditionally, adolescents have received the majority of their health care within the mainstream medical care delivery system. Today, public schools are beginning to provide health care services for adolescents, especially preventive health care services and counseling. Unlike most other health care services, school-based clinics do not require insurance and offer services free or at low cost. Currently, there are only 150 school-based clinics sponsored by school systems, public health departments, non-profit organizations, community health clinics and hospitals and medical

schools operating in junior and senior high schools in most major cities and some rural areas.[56] [57] The number of such clinics increased five-fold between 1983 and 1988.[58] These clinics serve mostly low-income, predominantly minority youth who otherwise have limited access to other sources of health care.

A survey conducted by the Center for Population Options in the spring of 1989 indicated that 59% of all clinic users are Black (up from 49% in 1988), 25% are White and 12% are Hispanic.[59] On the average, the survey found that 38% of clinic users are adolescent males. This is an encouraging statistic since adolescent males are typically very difficult to reach with health care services. Moreover, a recent study found that school-based clinics saw a larger proportion of males than did other adolescent health programs.[60] Most clinics limit eligibility to students enrolled in the school, although 16% are also open to dropouts. Another indication that school-based clinics serve disadvantaged adolescents is that roughly one-third of the clinic users have no health insurance.

A number of innovative models for a variety of health problems have been developed and tested in school-based clinics.[61] Some successful models include smoking prevention programs which have focused on decision-making and social skills-building.[62] Conversely, traditional programs which stress health risks have been notoriously unsuccessful.[63] In the areas drug and alcohol abuse, in contrast to smoking, few of the school-based programs have done more than increase knowledge.[64] Peer-led programs, instead of adult-led programs, however, show great promise.[65]

Since only 15% of all school-based clinics currently dispense contraceptives, compared with 28% in 1986, it is not surprising that Stout and Revere[66] found that the sex education programs have not been successful. According to survey data, school-based clinics have had no effect on pregnancy rates.[67] In view of the threat of AIDS and the rising rates of sexually transmitted diseases among teenagers, the inadequacy of contraceptive services at school-based clinics is especially striking. While these clinics have the potential of reaching many adolescents who may otherwise not have access to health care services, they are presently limited both in number and scope. Research from two programs which specifically targeted high risk adolescents showed that financial constraints severely limit public schools' ability to expand in the area of health services.[68]

In addition to the school-based clinics, other ways of providing services to adolescents have proved successful, for example, community-based clinics providing specialized services to young people. In 1981, the Robert Wood Johnson Foundation (RWJ) provided funds to 21 teaching hospitals to support community-based, comprehensive health services to high-risk adolescents, that is, adolescents living in communities with high rates of

sociomedical problems such as teenage pregnancy, drug abuse, accidents, homicide, suicide, and depression.[69] [70] The first step at each site was the creation of a health center that could provide both primary care and preventive services that otherwise were unavailable. Centers followed one of three models: the referral center (often an outpatient adolescent clinic at a teaching hospital); the in-school health center; and the freestanding community clinic. Although the in-school centers proved to be the best place to reach adolescent males,[71] their major problems were that some clinicians were unwilling to work in a school setting and secondly, some centers closed during summer vacation, school holidays and after school. The majority of clients at all centers were between 15 and 19; almost three-fourths were female. More than half of all clients served were Black, 30% were White and 16% were Hispanic.

Several important objectives were achieved by the RWJ-funded programs between 1981 and 1984.[72] First and foremost was the delivery of health services to high risk youth. The program directors found that many high-risk adolescents needed health services in addition to what was available to them and that they were more likely to seek services offered at comprehensive sites that provided both primary care and preventive services. Furthermore, results from this program indicated that teaching hospitals and community agencies could collaborate to provide comprehensive services to high-risk youth. The second objective achieved was the increased training in adolescent health by teaching institutions to a variety of health care providers. This was in light of the fact that few health care providers were trained in adolescent health care.[73] [74] Finally, the fragmentation of health care services,[75] especially for low-income adolescents, was substantially reduced. These projects acted as catalysts to raise awareness about adolescent health needs, focus on underutilized services, document gaps in services, eliminate duplication, share information, and organize a viable referral network.

Although most adolescents are healthy and there is no known reason to believe that multiple annual physician visits are necessary, infrequent contact with a physician means there is less opportunity to receive basic preventive care. The foregoing data indicate that minority and low-income adolescents are at greater risk of not receiving basic preventive as well as curative care. In particular, medical problems may not be identified early, and prescriptions, vision corrections, and other needed interventions are less likely to be provided. Innovative ways for providing these services have been tried and proven successful. The challenge is to apply this experience to make access to care available to many more minority adolescents.

Table 4.1

Sociodemographic Characteristics of Adolescents Aged 10 to 18 By Type of Coverage: United States, 1984*

Sociodemographic Characteristics	Persons With Coverage (%)†			Persons Without Coverage (%)
	Total‡	Private	Public	
Gender				
Male	85.5	75.9	11.2	14.5
Female	86.2	75.7	12.5	13.8
Race & ethnicity				
White, not Hispanic	88.9	83.4	7.1	11.1
Black, not Hispanic	81.9	56.5	27.8	18.1
Hispanic	70.2	52.1	19.5	29.8
Other	84.8	67.6	20.6	15.2
Poverty status§				
Below poverty level	69.1	32.1	39.7	30.9
Above poverty level	90.6	86.7	5.6	9.4
Family income ($)§				
<5 000	73.0	30.3	44.6	27.0
5 000–9 999	66.7	32.0	37.6	33.3
10 000–14 999	72.7	61.2	13.4	27.3
15 000–19 999	82.5	78.2	5.8	17.5
20 000–24 999	89.1	85.0	6.6	10.9
>25 000	93.0	88.8	5.7	7.0
Education of family reference person				
<9 y	60.6	34.9	26.6	39.4
9–11 y	72.4	47.6	26.8	27.6
High school graduate	86.0	77.2	10.8	14.0
Some college	90.3	82.7	10.0	9.7
College graduate	95.0	92.5	3.7	5.0
Postcollege	96.6	94.5	2.8	3.4
Living arrangement				
With both parents	88.6	83.8	6.3	11.4
With 1 parent	81.1	55.7	28.0	18.9
With other relatives	65.3	42.5	25.5	34.7
Alone or with nonrelatives	86.3	80.5	6.8	13.7
Region of residence				
Northeast	91.4	79.2	13.5	8.6
Midwest	89.8	80.7	10.4	10.2
South	81.2	72.0	11.0	18.8
West	82.5	71.8	13.4	17.5
Place of residence				
Metropolitan	87.2	76.3	12.7	12.8
Central city	83.2	64.9	20.1	16.8
Not central city	89.6	83.2	8.2	10.4
Nonmetropolitan	83.3	74.8	10.2	16.7

* From the National Health Interview Survey: original tabulations from public use tapes.
† Excludes persons with unknown coverage status.
‡ Total percentage may be less than the sum of private and public coverage because some persons have both types of coverage.
§ Excludes persons with unknown income.

Source: Newacheck PW, McManus MA. Health Insurance Status of Adolescents in the United States. Pediatrics 1989; 84(4):699-708, Tbl 2

Table 4.2

Sociodemographic Characteristics of Young Adults Ages 19 to 24, By Type of Coverage: United States, 1984*

Sociodemographic Characteristics	Persons With Coverage (%)†			Persons Without Coverage (%)
	Total‡	Private	Public	
Gender				
Male	70.5	67.1	4.3	29.5
Female	76.6	65.9	12.1	23.4
Race & ethnicity				
White, not Hispanic	77.3	72.1	6.2	22.7
Black, not Hispanic	65.8	49.6	18.4	34.2
Hispanic	55.8	49.6	9.5	44.2
Other	70.4	61.3	10.2	29.6
Poverty status				
Below poverty level	63.6	43.0	22.4	36.4
Above poverty level	77.7	74.1	4.7	22.3
Family income ($)				
<5000	71.0	52.6	20.6	29.0
5 000–9 999	54.1	38.9	16.3	45.9
10 000–14 999	67.3	60.3	8.0	32.2
15 000–19 999	75.0	70.5	5.8	25.0
20 000–24 999	79.0	73.9	5.4	21.0
>25 000	79.9	77.1	4.0	20.1
Usual activity				
Working	73.9	71.3	3.1	26.1
Employed	76.0	74.1	2.4	24.0
Unemployed	46.2	39.7	6.9	53.8
Keeping house	68.1	39.3	29.3	31.9
Going to school	81.3	76.7	6.2	18.7
Other	50.1	30.5	24.2	49.9
Education of family reference person				
<9 y	50.8	37.3	14.4	49.2
9–11 y	57.1	39.1	19.5	42.9
High school graduate	71.9	64.2	8.8	28.1
Some college	79.4	75.1	5.3	20.6
College graduate	85.1	83.6	2.1	14.9
Postcollege	87.8	86.0	3.8	12.2
Living arrangement				
Alone	81.8	79.6	3.0	18.2
With nonrelatives only	73.2	71.5	2.6	26.8
With spouse	75.2	67.9	7.8	24.8
With other relatives	71.2	62.5	10.4	28.8
Region of residence				
Northeast	78.9	70.4	9.2	21.1
Midwest	77.1	69.7	8.4	22.9
South	70.7	65.0	7.0	29.3
West	68.4	60.6	9.3	31.6
Place of residence				
Metropolitan	74.6	67.4	8.3	25.4
Central city	70.4	60.1	11.3	29.6
Not central city	77.5	72.6	6.2	22.5
Nonmetropolitan	71.3	64.3	8.2	28.7

* From National Health Interview Survey; original tabulations from public use tapes.
† Excludes persons with unknown coverage status.
‡ Total percentage may be less than the sum of private and public because some persons have both types of coverage.

Source: McManus MA, Greaney AM, Newacheck PW. Health Insurance Status of Young Adults in the United States. Pediatrics 1989; 84(4):709-716, Tbl 1

Table 4.3

Average Number of Annual Office Visits for Adolescents and All Other Age Groups By Sex, Race, and Age: United States, 1980-1981

Sex and Race	Age 11-14 years	15-20 years	11-20 years	All other ages
Sex				
Both sexes	1.40	1.79	1.65	2.81
Female	1.42	2.19	1.91	3.26
Male	1.38	1.39	1.39	2.31
Race				
White	1.51	1.92	1.77	2.91
Black	.89	1.24	1.11	2.39
Other	.95	.50	.67	1.27

Source: Compiled by Policy Research Incorporated based on information from National Center for Health Statistics. Cypress BK. Health Care of Adolescents by Office-Based Physicians, National Ambulatory Medical Care Survey, 1980-1981. Advance Data from Vital and Health Statistics, No. 99. DHHS Pub. No. (PHS) 84-1250. Public Health Service. Hyattsville, MD, Sep 28, 1984, Tbl 1

Table 4.4

Number of Office Visits Made by Adolescents and All Other Age Groups and Percent Distribution by Selected Visit Characteristics, According to Age: United States, 1980-1981

Characteristic	Age		
	11–14 years	15–20 years	All other ages
	Number in thousands		
All visits	40,269	67,172	1,033,482
	Percent distribution		
Total	100.0	100.0	100.0
Sex			
Female	49.4	61.3	60.6
Male	50.6	38.7	39.4
Race			
White	88.8	89.7	89.4
Black	9.4	9.7	9.5
All other	1.8	0.7	1.1
Hispanic origin			
Hispanic	4.6	3.4	4.6
Non-Hispanic	95.4	94.6	95.5
Prior visit status			
New patient	18.3	20.8	13.7
Old patient, new problem	31.7	26.1	31.6
Old patient, old problem	50.0	53.2	54.7
Major reason for visit			
Acute problem	47.2	41.0	35.6
Chronic problem, routine	20.5	19.4	29.1
Chronic problem, flareup	6.2	5.7	9.6
Postsurgery or postinjury	9.4	9.9	8.7
Nonillness care	16.8	24.0	17.1

Source: National Center for Health Statistics. Cypress BK. Health Care of Adolescents by Office-Based Physicians, National Ambulatory Medical Care Survey, 1980-1981. Advance Data from Vital and Health Statistics, No. 99. DHHS Pub. No. (PHS) 84-1250. Public Health Service. Hyattsville, MD, Sep 28, 1984, Tbl 2

Table 4.5

Health Care Utilization of Children and Adolescents by Selected Characteristics: United States, 1988

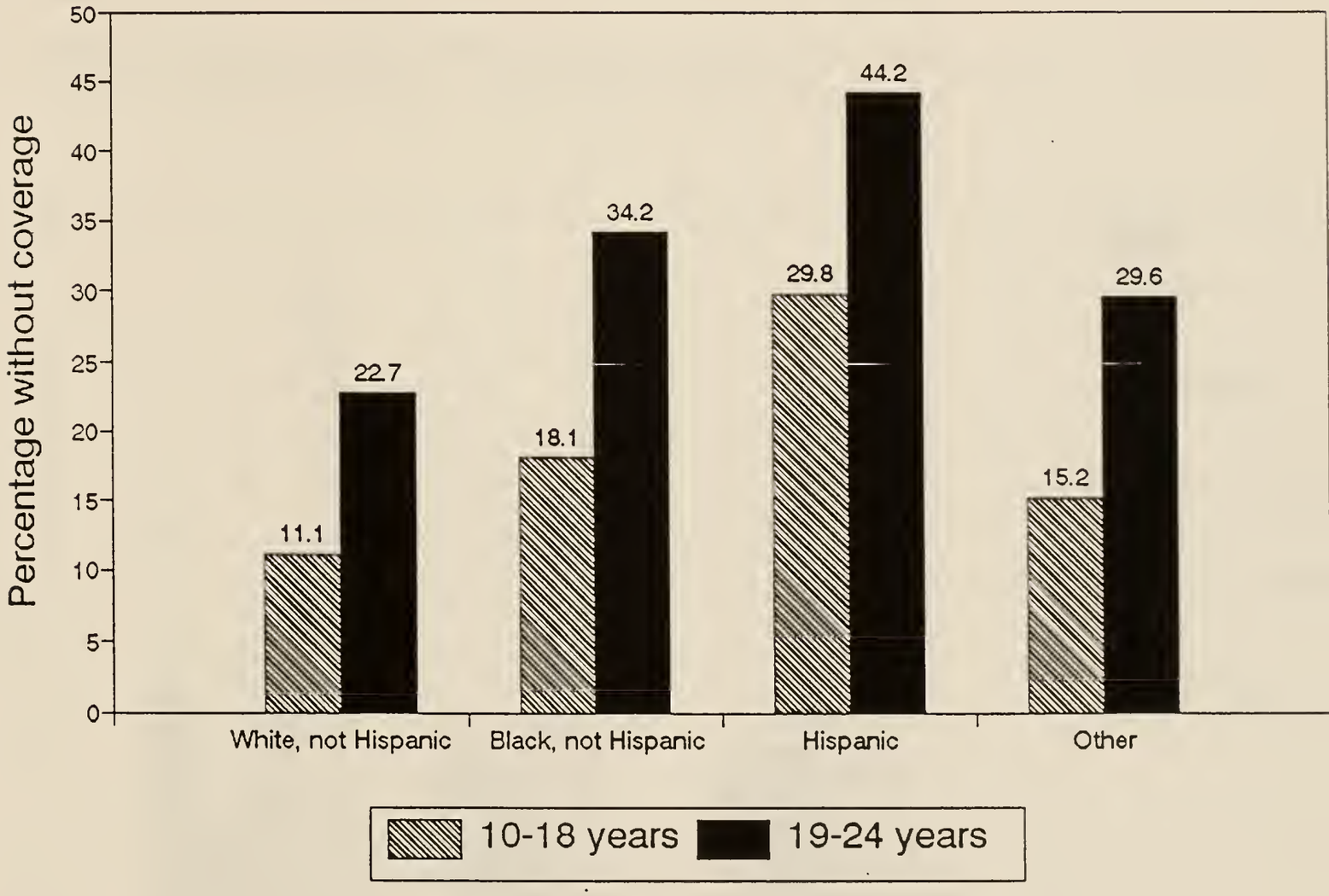
Characteristic	Physician contact		Hospitalization
	Contacts per person per year	Persons with 1 contact or more in past year	Persons with 1 hospital episode or more in past year
Race and age	Number	Percent	
White:			
Under 18 years	4.8	81.8	3.6
0–4 years	7.5	93.6	5.6
5–11 years	3.8	79.1	2.2
12–14 years	3.2	73.3	2.3
15–17 years	3.8	75.7	[1]4.5
Black:			
Under 18 years	2.9	75.8	4.0
0–4 years	4.6	91.7	6.6
5–11 years	2.3	71.8	2.1
12–14 years	2.0	66.0	1.7
15–17 years	2.5	68.0	[2]5.8
Income			
Less than $10,000	4.4	78.3	5.8
$10,000–$19,999	3.5	75.3	4.0
$20,000–$34,999	4.6	81.1	3.4
$35,000 or more	5.2	85.6	2.9
Geographic region			
Northeast	4.5	87.6	2.9
Midwest	4.7	82.2	4.2
South	4.1	77.3	4.3
West	4.7	78.8	2.6

[1] The percent excluding hospitalizations for delivery is 3.6.
[2] The percent excluding hospitalizations for delivery is 3.5.

Source: National Center for Health Statistics. Current Estimates from the National Health Interview Survey, 1988. DHHS Pub. No. (PHS) 89-1501. Series 10, No. 173, Oct 1989, Tbl F

Figure 4.1

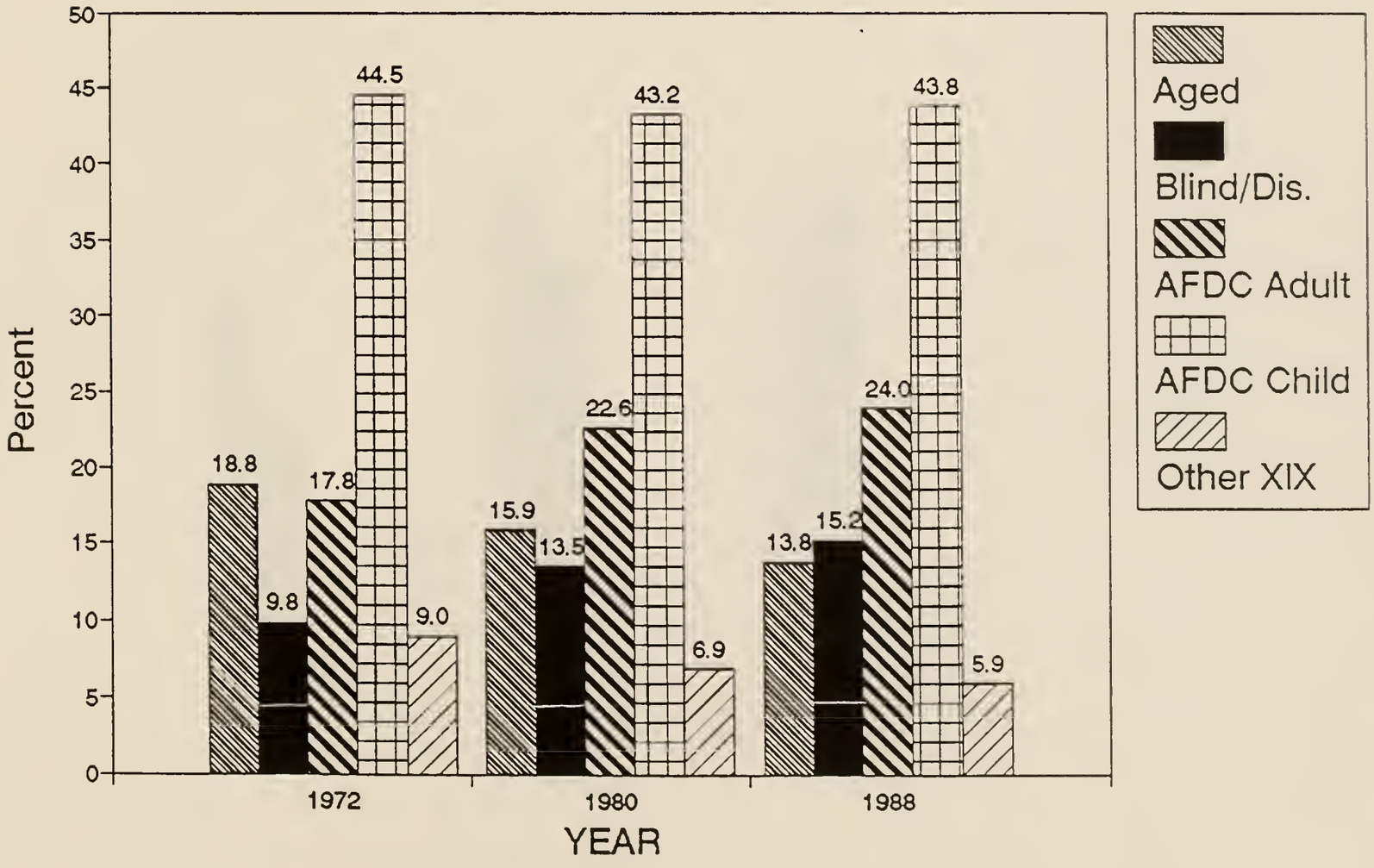
Adolescents and Young Adults Without Insurance, By Race: United States, 1984



Source: Figure prepared by Policy Research Incorporated, based on data from: Newacheck PW, McManus MA. Health Insurance Status of Adolescents in the United States. Pediatrics 1989; 84(4):699-708, Tbl 2 and McManus MA, Greaney AM, Newacheck PW. Health Insurance Status of Young Adults in the United States. Pediatrics 1989; 84(4):709-716, Tbl 1

Figure 4.2

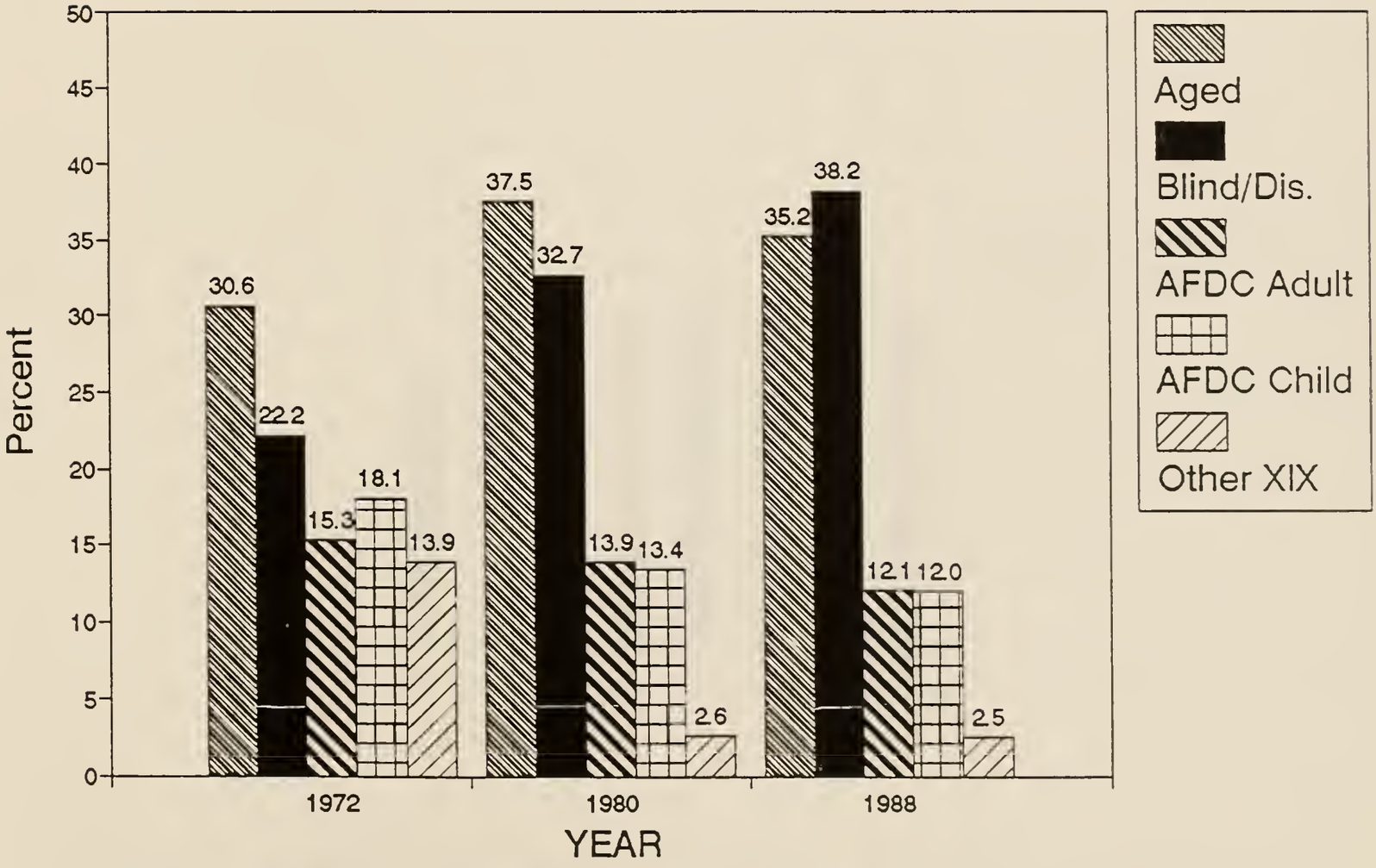
Medicaid Recipients, According to Basis of Eligibility: United States, Selected Years 1972, 1980 and 1988



Source: National Center for Health Statistics, "Health, United States, 1989," Department of Health and Human Services Pub. No. (PHS)89-1232, Washington, DC: U.S. Government Printing Office, March 1990, Tbl 127, p. 256

Figure 4.3

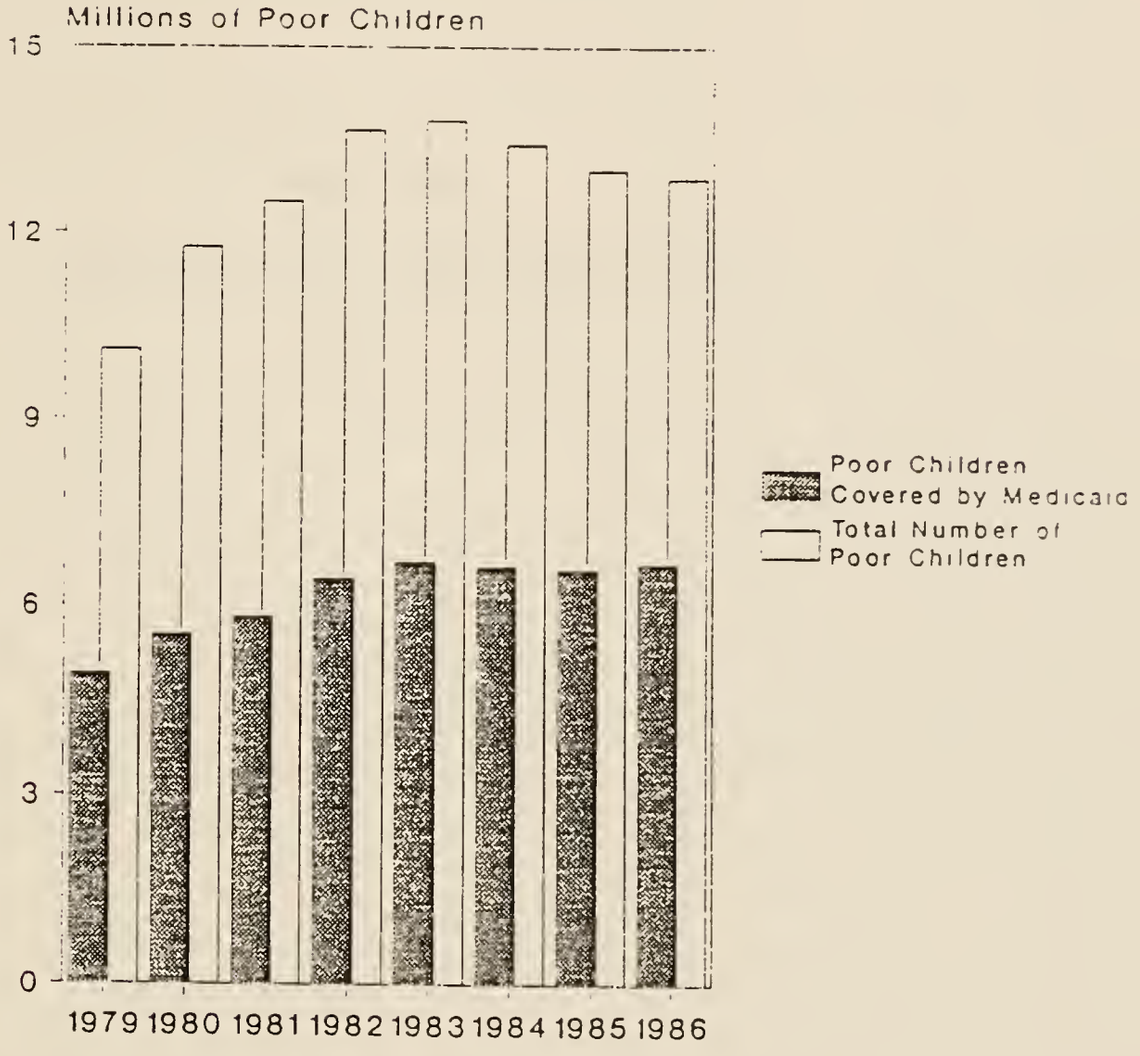
Medical Vendor Payments According to Basis of Eligibility: United States, Selected Years 1972, 1980 and 1988



Source: Congressional Research Service, Committee on Energy and Commerce, U.S. House of Representatives, "Medicaid Source Book: Background Data and Analysis," Nov 1988, U.S. Government Printing Office, Figure I-2, p. 3

Figure 4.4

Number of Poor Children Under Age 18 Covered by Medicaid, 1979-1986



Source: Congressional Research Service, Committee on Energy and Commerce, U.S. House of Representations, "Medicaid Source Book: Background Data and Analysis," Nov 1988, U.S. Government Printing Office, Figure B-5, p. 337

PART FIVE:

CONCLUSIONS AND RECOMMENDATIONS

5.1: OVERVIEW TO CONCLUSIONS AND RECOMMENDATIONS

Adolescent minority males, as do other population groups, live in a dynamic and complex system which impacts directly on their health and well being and that of their families. However, this complex system has significantly more disturbing consequences on their overall quality of life than it does on the adolescent population in general. While the manner in which socioeconomic and environmental factors (e.g., housing, education, income and employment) interact with personal characteristics within this very complex system to produce varying health outcomes is unclear, this report has described those factors and their interrelationships insofar as the data are available.

Many of the conclusions and recommendations presented in this section of the report cross multiple areas of concern; insofar as possible, we have described the conclusions and defined the recommendations such that they can provide a useful framework for the policy making process in directing relevant public health and social interventions to impact the health and social well being of America's youth. The fact that many of these recommendations are not new, having been made in many diverse settings for some time, is indicative of the necessity to have a defined and broadly based social and health policy which is directed toward this severely disadvantaged and at-risk group of American youth.

One example of a previous related report which included recommendations for action vis-a-vis minority youth is the Report of the Secretary's Task Force on Black & Minority Health, issued in 1985, addressed a number of the concerns reflected in this report. However, while the Task Force recognized the importance of sociocultural factors vis-a-vis health status, it did not extensively describe them, and the only recommendation which concerned sociocultural factors related to the conduct of further research. Other studies of particular health problems (e.g., drug abuse, violence) or social issues (e.g., education) have presented specific recommendations relevant to those problems and issues, but often do not present recommendations which recognize the systemic nature of adolescent health and social needs.

The conclusions and recommendations which follow from this report are presented in three sections, as follows:

* socioeconomic factors related to the health status of adolescent minority males,

* health status and health services related to adolescent minority males, and

* data limitations, together with the research which could be undertaken to produce information which might contribute to the development of public and private sector policies and programs designed to address the needs of adolescent minority males.

The Recommendations take as a point of departure the World Health Organization's comment on achievement of the Health for All by the Year 2000 objectives, to which the U.S. is a signatory. For each individual country to achieve these objectives, the WHO suggests that:

> 'Health for all' is thus a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, just as much as in medicine and public health... The adoption of 'health for all' by a government implies a commitment to promote the advancement of all citizens on a broad front of development, and a resolution to encourage the individual citizen to achieve a higher quality of life. The rate of progress will depend on the political will [of each individual country]."[1]

CONCLUSIONS	RECOMMENDATIONS
1. Socioeconomic Factors Related to the Health Status of Adolescent Minority Males	
1.1 For Black, Hispanic and Native American adolescent males, the problems of health status are exacerbated by profound and pervasive disadvantages with respect to education, employment, and family economic and social stability, relative to White adolescent males. The interrelationships of these multiple cofactors are inextricably tied and have important implications for both the present and future health status of minority adolescent males.	1.1.1 The urgency of the myriad problems which confront minority adolescent males requires immediate and systematic intervention at the federal, state and local levels by the public and private sectors. The Department of Health and Human Services (the Department) should, as an initial step toward the formulation of a more rational intervention strategy, develop a comprehensive description of the many disparate federal, state and local programs which impact on adolescent minority males, identify the opportunities for linkages among these programs, and determine the need for specific additional policies and programs designed to address these critical needs.
	1.1.2 The Department should establish at the Secretarial level an interagency task force designed to assess the responsiveness, relevance and impact (including positive and unintended negative impact) of agency policies, procedures and programs. Included in this process should be the examination of relevant recommendations made by Departmental bodies (including the Secretary's Task Force of 1985) to determine the degree to which those recommendations have been followed in Departmental policies and programs.

Based on that examination, the Department should formulate a rational intervention strategy which takes into account disparite and independent programs and unifies them in a systematic policy and set of programs. One primary step toward promulgation of this strategy is the development of short range plans to redirect significant Department-wide resources to address the various health and social welfare problems of adolescent minority males within the purview of the Department's authority.

1.1.3 A Cabinet-level Interdepartmental Task Force or Commission should be established to examine existing federal policies and programs relevant to adolescent minority males and to formulate more rational interdepartmental intervention strategies. This should include, but not be limited to, a determination of the degree to which adolescent minority males are the victims of discrimination by virtue of disparities in policies and programs (including but not limited to expenditures) at the federal level and in the private sector.

Within this context, for example, the Department can work with the Department of Labor (DOL) and the Department of Education (DOE), as well as the private sector, to examine the effectiveness of existing education, training and employment programs with respect to adolescent minority males. This Task Force (or Commission) can also

1.2 A significant proportion of adolescent minority males live in social conditions which are correlated with their significantly higher rates of mortality and morbidity, particularly those related to at-risk behavior, including violence (e.g., homicide, drug abuse, adolescent prostitution) which leads to injury, illness or death. They also are victims of discriminatory practices on the part of local criminal justice agencies, which places them at-risk for continued high-risk behavior.

design (and recommend funding allocations for) specific policies and programs that can address the training and employment needs of adolescent minority males.

1.2.1 Through the DHHS Interagency Task Force, the Department should develop policies and programs to address the public health dimensions of both intentional and unintentional injuries. Through the Interdepartmental Task Force (or Commission) described in Recommendation 1.1.3, the Department should cooperate with the Department of Justice in identifying policies and programs which can address the problems of 1) violence within and across racial and ethnic as well as socioeconomic and neighborhood groups, 2) discrimination with regard to the processing of adolescent minority males through the juvenile justice system, and 3) the physical and mental health consequences of adolescent minority male involvement with the criminal justice system. Such programs could include, for example,

1) provision of support for the development and implementation of model school-based programs such as conflict resolution training programs, and early identification of and counseling for at-risk youth,

2) support for the development and implementation of innovative programs directed toward minority adolescent school dropouts,

3) support for the development and implementation of innovative programs directed toward the families of homeless minority adolescent males, and

4) examine reasons for disparities in arrests patterns and convictions of racial and ethnic minority adolescents, and design and implement police training programs directed toward the elimination of discriminatory practices which may be identified.

1.2.2 In an effort to reduce the number of injuries and deaths related to violence, the Department should, through the Cabinet-level Interdepartmental Task Force, cooperate with national and local criminal justice officials to devise specific legislation and preventive programs which would address the specific gun-related violence among adolescents, utilizing available public health and other data.

1.3 A significant proportion of adolescent minority males live in physical conditions (e.g., unsafe and crowded housing conditions) which contribute to their disproportionately higher rates of illness (e.g., lead poisoning, tuberculosis and respiratory conditions), injury and death.

1.3.1 Through the Interdepartmental Task Force described in Recommendation 1.1.3, the Department should work with other federal agencies and with the private sector to develop policies and programs which address 1) the critical need for inexpensive and safe temporary and permanent housing for adolescent minority, low-income youth, and in particular for those who are homeless, and 2) the health and educational needs of homeless, migrant and institutionalized adolescents.

2. Health Status and Health Services Availability

2.1 By many measures of health status, the adolescent minority male is at a significant disadvantage in comparison to his White counterpart. The health status measures which evidence particularly significant disparities include, for example: mortality rates, including life expectancy at age 21; intentional and unintentional injuries (in particular, homicide); sexually transmitted diseases (STD's), including HIV; developmental effects of lead poisoning; abuse of illegal drugs and smoking; nutrition; and acute and chronic diseases, including physical and mental disorders.

2.1.1 The Department should establish a mechanism for the review of all relevant health education and prevention materials and programs directed toward adolescents and youth to ensure that they address the needs of and are sensitive to adolescent minority males.

2.1.2 In order to improve the nutritional status of adolescent minority males, the Department, through the Interdepartmental Task Force, should take action to examine federal and state programs designed to meet the needs of this population, including, for example, WIC, Food Stamp, school lunch, migrant health, and Indian Health programs. The Department should also develop strategies for incorporating nutritional education within these programs.

2.1.3 The Department should significantly increase its efforts to prevent STDs among adolescent minority youth and to ensure that adequate early treatment is available and utilized. In addition to the use of school-based activities (including school-based clinics), alternative strategies should be explored, including programs implemented at facilities frequented by youth (recreation centers, shopping centers) and community-based programs organized by churches and ethnic organizations. The direct objective of these programs should be to significantly

increased involvement of the adolescent minority male in teenage pregnancy programs (both preventive and those concerning pregnant teenagers). These programs should have particular focus on sex education which addresses male responsibility, and at the same time provide both adequate information for informed choices and support services which address their ability to assume responsibility (e.g., education and job counselling and referral).

2.1.4 The Department should significantly increase its efforts to prevent HIV among adolescent minority youth and to ensure that adequate early treatment is available. In addition to the programs described above for STDs, the Department should recognize the importance of 1) targeting prevention strategies specifically to racial and ethnic minority populations (in particular to Black and Hispanic youth), 2) ensuring access to educational materials which describe in as clear a manner as possible the range of approaches to HIV prevention (including abstinence and safe sex practices), and 3) encouraging school-based health centers, community health centers and other facilities to make condoms available to sexually active adolescents.

2.1.5 The Department should take immediate steps to 1) identify the most appropriate mental health prevention and treatment methodologies directed toward the specific needs of minority adolescent populations (e.g., Black, Hispanic, Native American and

Asian American immigrants), 2) provide support for demonstration, community-based mental health services.

2.1.6 The Department should expand targeted efforts designed to reduce the incidence and prevalence of substance abuse among adolescent minority males, including examining the validity of the full range of prevention strategies directed toward this population within the past 20 years. Based on the results of this examination, and in cooperation with DOE and DOL, the Department should 1) direct comprehensive efforts toward school dropouts, 2) increase support to community-based prevention programs which target adolescent minority males, particularly those which are linked to education and employment/training activities, and 3) support the state and local strict enforcement of sale of alcohol to minors and the use of alcohol tax for substance abuse prevention programs. It is critical that these policies and programs recognize the importance of sociocultural targeting of prevention strategies.

2.1.7 The Department should continue and expand upon the efforts of the Secretary to reduce the incidence of tobacco use among adolescent minority males, including the strict monitoring of cigarette advertising directed toward minority communities and minority adolescents in particular.

2.2 Low income adolescent racial and ethnic minority youth, including males, have limited financial access to preventive and curative health services, severely hampering the potential for early detection and treatment of a wide range of health problems.

2.1.8 Through the Cabinet-level Interdepartmental Task Force, the Department should work with the Department of Juvenile Justice in the identification of specific public health and other approaches to reducing the excessive homicide rates among Black and Hispanic adolescent males.

2.2.1 The Department should 1) support the expansion of public sector health insurance coverage to include all low-income (to 150% of poverty level nationwide) children and adolescents to age 21, including coverage of preventive services, 2) expand funding for community health and school-based health centers, to ensure that all adolescents have access to adequate health care and 3) coordinate with the Job Corps program to expand their health services programs.

2.2.2 The Department should provide support for the training of health personnel to work specifically with adolescent minority youth, in particular with low-income adolescent minority youth, and should provide support for programs which provide incentives for health personnel who work with this population.

2.2.3 The Department should 1) significantly increase the availability of mental health diagnostic and treatment services available to minority adolescent youth, 2) train mental health workers (minority and White) to work with minority adolescent youth, and 3) train school-based health and guidance personnel in the early

diagnosis of and counselling for mental health problems and in the development of referral services networks for racial and ethnic minority youth.

3. Data Limitations and Requirements

3.1 Data which are necessary in order to develop specific and effective policies and programs in response to the critical health needs of adolescent minority males exhibit crippling deficiencies in numerous subject areas. Most national data, including those collected directly by DHHS, or whose collection is funded by DHHS, are rarely disaggregated such that they allow for identification of specific problems by race/ethnicity, age and sex. Moreover, methods of data collection which are commonly used or funded by the Department, such as household surveys, may be inappropriate for the population of concern. This severely hampers the ability of the public and private sectors to adequately describe the health status of minority adolescent males and to meet their needs.

3.1.1 The Department should require that all nationally collected data funded by the agency or collected on an intramural basis allow for disaggregation by race/ethnicity (at the most discrete breakdown possible), sex and age.

3.1.2 The Department should provide support for the design and implementation of innovative methods of data collection, in particular with regard to health problems which pose inherent difficulties (e.g., substance abuse, sexual practices, violent behavior).

3.1.3 The Department should identify key indicators of adolescent minority health and ensure that data are collected and published on an annual basis (e.g., utilizing the indicators included in the Secretary's Task Force Report and the DHHS Year 2000 Objectives) in order to ensure on-going monitoring of the health of this population.

3.1.4 The Department should collaborate with other federal agencies and with state agencies and the private sector to ensure that key socioeconomic indicators for adolescent minority males are collected and reported on an annual basis.

3.1.5 The Department should significantly increase the funding available for research targeted toward the health status of adolescent minority males, with a particular focus on community-based research which incorporates specific prevention or treatment strategies.

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